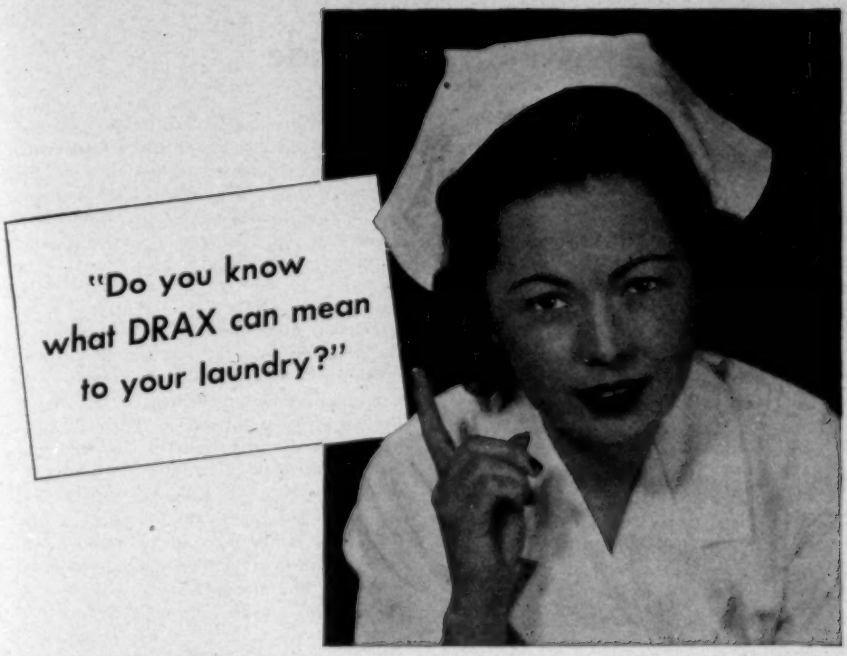

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Reader's Guide

We have been very gratified from time to time to read in your letters the highly commendatory remarks on the articles appearing in the *Journal*. Even this section has come in for its share of approval. Frequently, we are asked why we do not have a specific column entitled "Letters to the Editor" or some such thing where subscribers might air their views on controversial topics. We are willing, nay eager, to start this but feel it would serve a useful purpose only when such letters raise points of argument or disagreement. To publish all of the nice things you write us would certainly look like boasting. You are invited to send questions to the *Journal* for which other subscribers may be able to supply the answers. You are invited to supplement the information contained in any of the articles with additional data from your own experience. You are even invited to suggest a suitable name for such a column if and when we get enough letters rolling in to make its inclusion practicable.

Here is a sample of the sort of comment we would like to have: "I am very much interested in the three articles on tuberculosis in the December issue. I heartily agree with Miss Mabel Sharpe's article on 'Should Student Nurses have Experience in Tuberculosis Sanatoria?' Later I wish to write more along this line."

—E.M.R.

We look forward to receiving E.M.R.'s contribution.

The clear explanation of the use of electroencephalography, which has been prepared by **Dr. Herbert H. Jasper** and **Margaret Goldie Jasper, R.N.,** will be for many their first authoritative information on this topic. Don't let the nine-syllable word scare you away from reading this article. It is well worth your study. Dr. Jasper is on the staff of the Montreal Neurological Institute and of the Department of Neurology and Neurosurgery of McGill University.

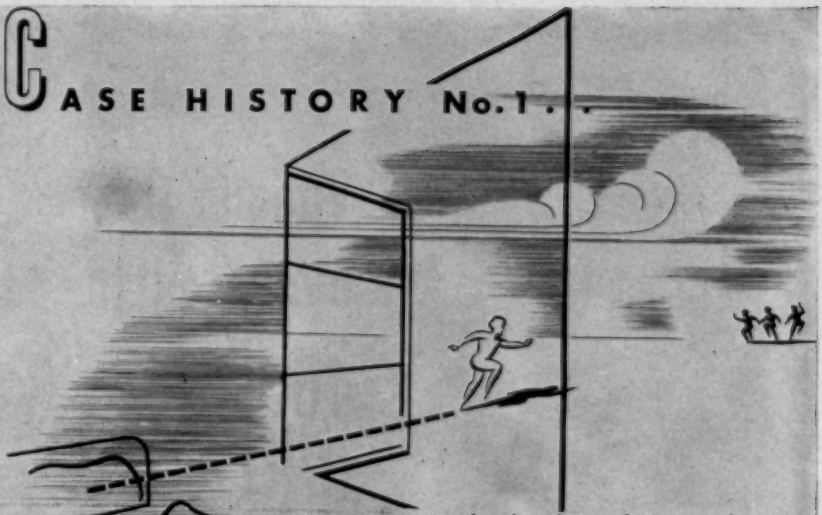
Some of the most impelling of the social controls have had their origins in the distant past of our race. Their imposition by thoroughly well-meaning parents has often left emotional scars which only a psychiatrist can help to remove. Two of these, guilt and anxiety, are discussed by **D. Ewen Cameron, M.D.** If we can learn to apply his sound advice we will be a long stride closer to acting like rational human beings. Dr. Cameron is director of the Allan Memorial Institute of Psychiatry in Montreal.

Student nurses need to become aware of the possibilities for healing the mentally ill which exist today. **Mildred Nelson,** who is assistant superintendent of nurses at the Provincial Mental Hospital, Ponoka, Alta., has given us a detailed study of what psychiatry should contribute to the nurse's fund of knowledge. **Ella G. Smith** has completed the picture by showing us how psychiatric affiliation can be worked out. Miss Smith was acting superintendent of nurses at the Ontario Hospital, Kingston, at the time she prepared her material.

It is recognized that every phase of the child health program is important but **Alice G. Nicolle** takes as her thesis the fact that many health programs have been initiated through the beginnings made in the care of school children. Since the average child is six when he commences school, valuable years for the correction of physical defects, for the establishment of immunities, and for the solving of behavior problems are lost. Miss Nicolle is educational supervisor with the Division of Nursing, Ontario Department of Health.

The very special attention of all instructors in our schools of nursing is directed to the suggestions regarding teaching made by the well-known educational authority, **S. R. Laycock, Ph. D.** Dr. Laycock's advice is so sound that its adoption in all of our schools of nursing would effect a minor revolution in student learning. Students taught by these methods would be more alive to all the situations which confront them. Dr. Laycock's suggested methods are not new to education but they will be new to many hospital instructors. Dr. Laycock is professor of educational psychology at the University of Saskatchewan.

CASE HISTORY No. 1 . .



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See article reprinted in Canadian Medical Journal, June 1944, Vol. 50. (E. M. Martin, M.D.)

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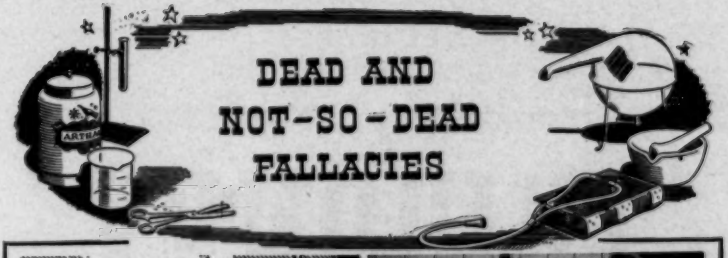

A STY, according to an old belief, should be treated by having it licked by a dog. When this treatment failed, the patient might try striking it nine times with a tomcat's tail, or rubbing it with a wedding ring.

STILL WIDESPREAD among people of this generation is the idea that canned foods should be cooked. This, of course, is not so—for, in the canning process, foods are thoroughly cooked. To serve, they need only be heated and seasoned to taste.

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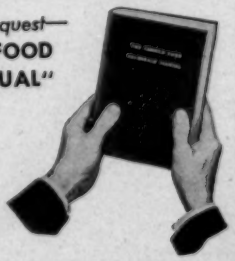

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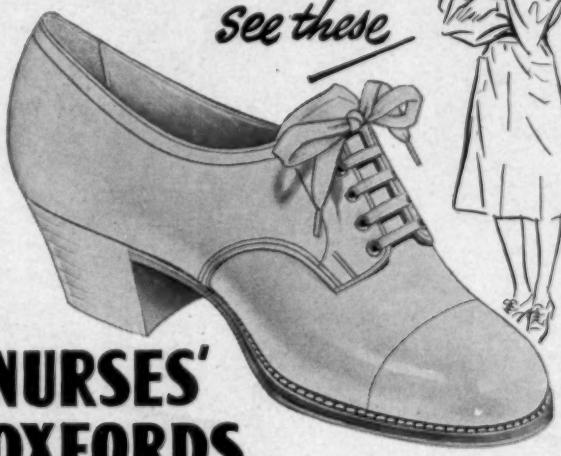

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A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-THREE NUMBER TWO

MONTREAL, FEBRUARY, 1947

Providing the Keys

Books are keys to wisdom's treasure;
Books are gates to lands of pleasure;
Books are paths that upward lead;
Books are friends. Come, let us read.
—EMILIE POULSSON

SINCE PRIMITIVE TIMES, mankind has sought some medium for preserving a record of events as they transpired. The Egyptians engraved inscriptions on stones, on the walls of their monuments and on columns. The Assyrians pressed their records upon tablets, which were hardened by baking. The Greeks and Romans used tablets of wood coated with wax on which letters were traced with a stylus. Two such tablets, joined together at the back with wires, are the earliest arrangement which resembles the modern book. A raised margin was left around the edge of the wooden tablets to prevent the wax from rubbing.

Papyrus furnished the first flexible material for writing, then parchment, then paper pressed from cotton or linen fibres. The first real impetus to the production of books came in the Middle Ages. Though the quality of the paper was poor by our standards, many of the books produced at this time were marvels of beauty and workmanship. Their production might take a lifetime since everything was done by hand. Few persons could read and the supply of books was sharply limited. Then, about 1450, John Gutenberg perfected his invention of printing from movable types and a new era had dawned. Books did not immediately become plentiful but gradually there were improvements in both quality and quantity. Today, that person is poor indeed who does not possess a few favored volumes.

One of the most vicious assaults

that was made by the conquering hordes of the enemy during the recent war was upon the books and libraries. Nothing was sacred—nothing was spared. Only books steeped in the brew of the current ideologies were permitted and the content of these was so dyed by the contact that they were worthless as valid reference texts. Nursing libraries never had been so extensive as those with which we are familiar. With the destruction of such books as were available, our colleagues were abruptly thrust back into a literary gloom as deep as the pre-Gutenberg days of the Middle Ages. Not only are there no nursing texts today, there is no paper on which to print them, nor are there many authors equipped with the latest information on nursing developments to write the texts.

It is to fill this breach that the nurses of Canada are asked to assist. Books on nursing practice in all of the widely diverse branches, books on the medical aspects of the various diseases, medical dictionaries, nursing manuals, books—books—books. Not just a few individual volumes but hundreds of books are needed to bring guidance and assistance to our colleagues in all of the countries which were so badly disabled by the war. The need is now—not in some distant future.

With the object of honoring all of the nursing sisters who served in World War II, the Canadian Nurses' Association has given its approval to an active campaign to raise a large sum of money as expeditiously as possible for the purchase and distribution of these books. Committees are to be set up in each provincial association to co-operate with the National War Memorial Committee in raising this money. The special drive will commence this month and continue until May 1, 1947. Provincial associations have been allocated specific objectives based on an approximation of the number of nurses, graduate and student, in each province, as follows:

Alberta	$ 2,000
British Columbia	3,700
Manitoba	2,000
New Brunswick	900
Nova Scotia	1,600
Ontario	10,000
Prince Edward Island	200
Quebec	10,000
Saskatchewan	1,600
Total	$32,000

In round figures, that is less than a dollar per person. If that total can be passed, it will mean just that many more books. If every nurse in Canada, active or retired, young or old, contributes one dollar as a part of a useful and active memorial, thousands of nurses in all parts of the world will benefit.

Contributions may be sent to your provincial nurses' association or directly to the Canadian Nurses' Association, 1411 Crescent St., Montreal 25. Cheques should be made payable to the War Memorial Trust Fund.

It is planned to have a special book-plate prepared to commemorate the courage, fortitude, physical and mental sufferings of those who served. This will be affixed in each volume. The assembled libraries will be sent to the nurses' associations in the various countries where they will be available on loan to all who can read English.

The question quite naturally will occur to many nurses—what good will it be to send books written in English to these foreign lands? Fortunately for the purposes of this memorial, the great majority of nurse educators in the European and Asiatic countries read English readily. Where French textbooks are available, these will be supplied to supplement the English volumes. No attempt will be made by the special committee to provide translations. This is a long, arduous, expensive, and time-consuming task. The books are needed now.

The readers of *The Canadian Nurse* are urged to acquaint their professional friends with this project. Let us all unite in raising the desired sum quickly.

—M.E.K.

Electroencephalography

HERBERT H. JASPER, M.D. *and* MARGARET GOLDIE JASPER, R.N.

THE SUBJECT OF THIS ARTICLE must appear forbidding and uninteresting to many of the readers of this *Journal*. It represents a fascinating and relatively new method for recording the electrical activity of the brain, commonly known as "brain waves." The long word used to describe this new technique is not so difficult if broken into its three parts: electro — encephalo — graphy. It was derived from the Greek *elektron* relating to electric, *enkephalon* meaning the brain, and *graphein* meaning to write. It may be defined simply as a graphic record of the electrical activity of the brain.

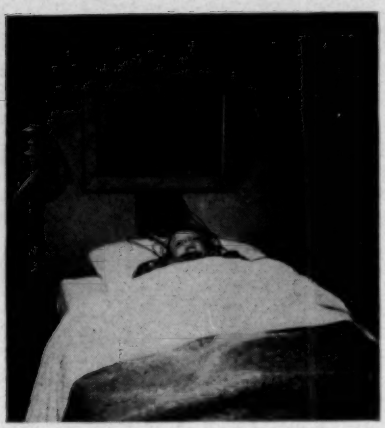
The word was first introduced by a German scientist and psychiatrist, Dr. Hans Berger, the man chiefly responsible for the establishment of this technique. He first called the records of the electrical activity of the brain "elektrenkephalograms." This was translated by English scientists into the hyphenated word "electro-encephalograms," and later the hyphen was dropped by American authors giving us the present "electroencephalogram" or E.E.G. for the records themselves, and "electroencephalography" for the complete technique of studying brain function by means of its electrical "brain waves." A specialist trained to take and to interpret the E.E.G. is known as an "electroencephalographer." There is now an association of such people called the "Eastern Association of Electroencephalographers."

The late Dr. Hans Berger, who was director of the Neuropsychiatric Institute and professor of psychiatry at the University of Jena, Germany, published his first paper describing the E.E.G. in 1929. This was followed by a series of papers in the *Archives für Psychiatrie* describing how an accurate record of the electrical activity of the human brain could be obtained through the intact skull and scalp. The principal features of the normal E.E.G. were established and various forms of abnormal waves associated with brain lesions and diseases were described. Berger received little recognition in his own country until the great English physiologist, Professor Adrian, and his colleague, Dr. Matthews, confirmed the fundamental observations of Berger and drew the attention of the scientific world to the importance of his discovery. Investigations were soon begun at Boston and Providence in the United States where the first clinical E.E.G. laboratories on this continent were established in 1935-36. Ten years later we find that electroencephalography has become an established technique of importance for the study of diseases of the brain comparable to electrocardiography for the study of diseases of the heart.

TECHNIQUE

Electrical activity of the brain is now usually recorded by means of electrodes attached to the scalp surface with collodion. Berger originally used needle electrodes inserted through the scalp to the skull, but it has been found that brain waves can be faith-

Method of attaching electrodes for electroencephalography. Small silver discs connected to a wire are attached on the head with collodion. Drying the collodion with a hair dryer is shown in this illustration.



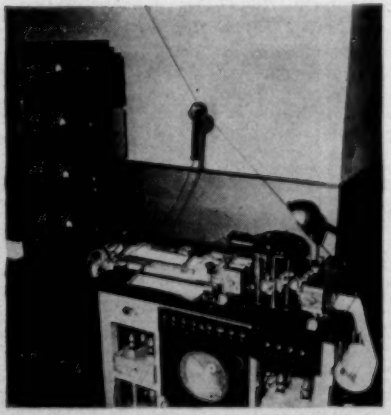
Patient placed in electrically-shielded quiet room with electrode wires placed in the plug-board ready for recording.

fully recorded without penetrating the scalp. When the brain is exposed during an operation they are recorded directly from the brain surface with small cotton covered electrodes held in a special holder attached to the edge of the skull opening. The scalp surface electrodes are small silver discs about 1 cm. in diameter, shaped like a small hat with a hole in the top. After they are attached to the scalp, an electrolytic jelly is inserted through this hole with a syringe so that a good electrical contact is made between the scalp and the electrode.

Fourteen to sixteen such electrodes are attached to the scalp for a complete examination from various brain areas beneath. The position of these electrodes is carefully measured so that they will be over approximately the same areas of the cortex in each patient. Electrodes are also placed on the ears for records from the under surface of the temporal lobes, and occasionally an electrode is placed through the nose on the posterior nasopharynx (the "basal lead") to obtain electrical activity from the base of the brain.

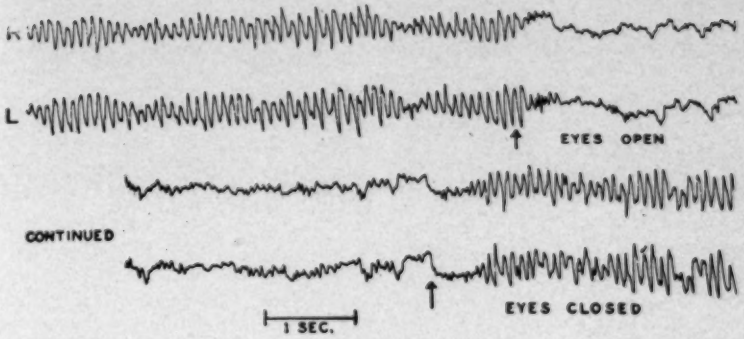
When the electrodes are all attached and the contacts assured, the patient is placed in a quiet, electrically-shielded room where all the wires from the electrodes are plugged into a board something like that used by telephone operators. The electrically-shielded room helps to eliminate electrical interference from elevators, x-ray, diathermy, and other sources which might be picked up by the extremely sensitive apparatus used to record the E.E.G.

Outside the room for the patient is placed the E.E.G. apparatus in front of a large viewing window where the operator may watch the patient while the records are being taken. The wires from the head are lead into a selector switch-box for connecting the apparatus to various combinations of electrodes. The minute electrical waves from the head are then amplified over one million times by especially designed vacuum tube amplifiers something like those used in radio. Four or six channels of recording apparatus are used simultaneously.



The electroencephalographic recording apparatus, which is placed outside the patient's room.

Brain waves are measured only in millionths of a volt (microvolts) so that extremely sensitive apparatus is required to amplify them sufficiently to make them activate fast moving pens on the recording paper. Consequently, the patient must rest very quietly for, when he moves, or even when the nurse moves about in the room with him, disturbances may be introduced into the E.E.G. record known as artifacts. Relaxation of



Sample of normal alpha rhythm from right and left occipital lobes as affected by opening the eyes.

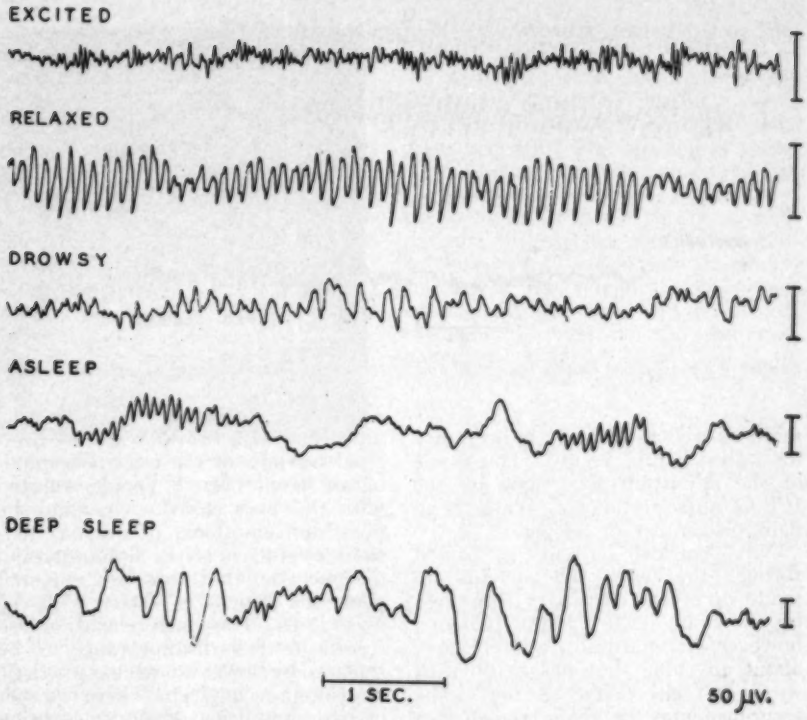
mind as well as of body is necessary for a good E.E.G. record. This is one of the important jobs done by the E.E.G. nurse-technician. There is no pain, discomfort, or danger.

No electrical current is passed through the head. The records are made up of the electricity generated by the brain itself. Many patients, however, are naturally apprehensive about anything that has to do with wires and electricity, so that some assurance may be required before a satisfactory examination may be obtained. This is especially true with young children and in patients with certain forms of nervous or mental disease.

Normal Electroencephalograms

In spite of the enormous complexity of the human brain its electrical activity appears to be quite simple. There is a dominant 10 per second rhythm of regular waves, most prominent from occipital regions, known as "alpha rhythm." (These waves were once called the "Berger Rhythm," but this terminology was discouraged by Berger himself who first called them "alpha wellen.") Of lesser prominence, and most clearly seen over sensory motor areas of the brain, are the "beta waves," less regular oscillations tend at about 20 to 30 cycles per second. Occasional waves of lower frequency are seen in the records from certain normal individuals, but the alpha and beta rhythms are the principal features of the electroencephalogram from normal people, relaxed with the eyes closed. Opening the eyes, and emotional or nervous tensions, tend to cause the alpha waves to disappear so that they are maximal when the patient is relaxed with the eyes closed. Too much relaxation also results in their disappearance, to be replaced by slower waves characteristic of drowsiness or sleep. There is a sort of basal condition of alert relaxation with the eyes closed which must be obtained in a patient in order to have an optimal E.E.G. recording.

Brain wave patterns and frequencies are very constant in a given individual from day to day if these basal conditions are maintained. There are wide differences, however, from one individual to another. An individual may be characterized by his brain wave patterns in a manner analogous to his finger-prints. This seems to be an hereditary trait since identical twins have almost identical E.E.G. patterns, although one pair of twins may show a very different pattern from another pair. This applies to certain abnormal brain waves as well as normal patterns, as will be pointed out later with reference to the epilepsies. It is presumed that these individual differences in brain wave patterns may have some relation to certain personality characteristics, but no such relationship has yet been clearly demonstrated.

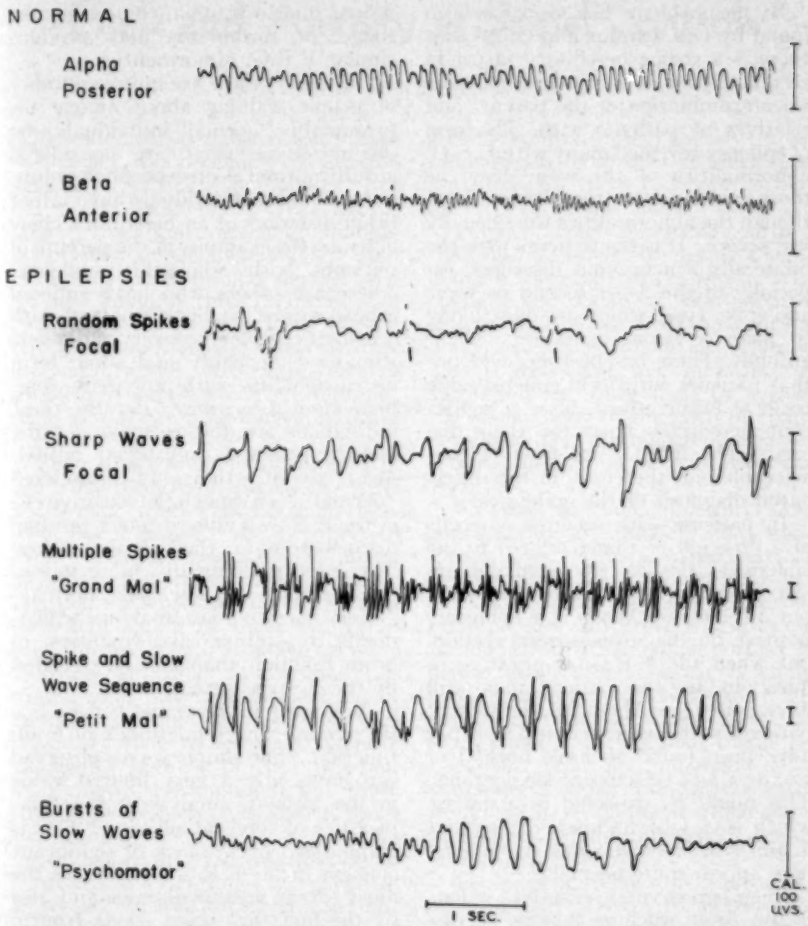


Sample electroencephalograms from a normal subject showing the effects of excitement, drowsiness, and sleep.

Abnormal Electroencephalograms

Most abnormal conditions of the brain which tend to depress its function, such as is seen grossly with a patient in coma, produce slow waves in the E.E.G. These slow waves, or delta waves, may range in frequency from 6 or 7 per second to less than 1 per second depending upon the severity of depression of brain activity. It is only in the most extreme stages of brain injury or disease that the brain waves actually disappear. Diseases which are associated with abnormal states of excitation within the brain, such as epilepsy and certain toxic conditions, are often associated with fast brain waves or "spikes." Hence the E.E.G. may be abnormal when the waves are too slow or too fast. This has been called cerebral dysrhythmia. Amplitude, regularity, and form of the waves are also of importance. Bursts of high voltage waves (called "paroxysmal") of most any form or frequency may indicate a tendency to brain disorder similar to that seen in patients with epilepsy. The particular form of the waves, and their localization, may indicate the origin and nature of the epilepsy.

The epilepsies may be divided into three major groups according to their electroencephalograms. There are first those showing a well-localized spike or sharp wave focus which usually indicates that part of the brain from which the seizures begin; this being often in the vicinity of a local brain injury or tumor. Another group of patients will show bursts of high voltage rhythmic waves often at frequencies of 3 or 6 per second with special patterns such as the "wave and spike" or "dart and dome"



Normal alpha and beta waves shown above as compared with various forms of abnormal discharges from epileptic patients.

forms. These waves appear simultaneously and synchronously from homologous areas of the two hemispheres. They probably arise from some sub-cortical source or pacemaker. It is in this group that we find most of the patients with so-called idiopathic epilepsy and those children with *petit mal* attacks and some with *grand mal* attacks as well. Patients with epileptoid behavior disorders or automatisms also frequently show bilaterally synchronous E.E.G. disturbances.

There is a third group of epileptic patients who show disorganized diffuse disturbances from all parts of the head, some fast and some slow, with a tendency for high voltage waves to appear periodically. These are known as the diffuse disorders and usually indicate a generalized rather than a local disease of the brain which is causing the epileptic seizures. Certain of these patients are also called "idiopathic" or "cryptogenic," meaning simply that the cause of their disease is unknown, or at least poorly understood.

By means of the E.E.G. it has been found by Drs. Lennox and Gibbs that there is a strong hereditary factor in certain forms of idiopathic epilepsy, since examination of the parents and relatives of patients with this form of epilepsy revealed many with E.E.G. abnormalities of the same form as those found in the patients themselves, though the abnormalities were usually less severe. It is the patients with the bilaterally synchronous disorders, especially of the 3 per second or wave and spike type, which are most likely to have a strong hereditary background. There has been no evidence that patients with focal epilepsy, due to local brain injury, have a significant hereditary basis for their disease. The E.E.G. has been of considerable aid, therefore, in the differential diagnosis of the epilepsies.

In patients with seizures or spells of a type not certainly related to the epilepsies, the electroencephalogram can often give a certain diagnosis, but not always. When it is definitely positive the diagnosis is quite certain, but when the E.E.G. is negative or questionable, the patient may still have epilepsy. About 10 per cent of patients with known clinical epilepsy have been found to have normal or borderline electroencephalograms. This might be expected in a disease which is variable and periodic, so that at times between seizures the E.E.G. may appear quite normal.

In progressive destructive lesions of the brain, such as tumors or vascular lesions, the site of the lesion may be localized by the E.E.G., most often by a focus of delta (slow) waves. Occasionally, the site of the lesion is revealed only by asymmetries in amplitude or frequency of the waves from the two sides of the head. Lesions lying deep within the brain are more difficult to localize. If a part of the brain has been removed, leaving no abnormal tissue behind, the E.E.G. may return to normal even though the patient may show marked paralysis or loss of mental function due to the loss of brain substance. Diagnosis of the pathological nature of the lesion cannot be made by the E.E.G. since lesions due to trauma, tumor, hemorrhage, or thrombosis may produce similar E.E.G. abnormalities.

Curiously, there are quite a number of people walking about among us, presumably "normal" individuals,who do not have what are considered strictly normal electroencephalograms. Some of these individuals have latent brain disorders of an hereditary character as, for example, in the parents of patients with idiopathic epilepsy. There are others who have suffered a head injury (at birth or after) with apparent complete recovery and others who have probably had some form of encephalitis with apparent complete clinical recovery. Because these individuals are able to make a satisfactory personal and social adjustment to life they are considered "normal" even though the sensitive eye of the E.E.G. is able to detect residual disturbances in their brain waves. There are undoubtedly more individuals among the so-called "normal" population who are making adjustments to minor abnormalities of brain function than can be detected by the electroencephalogram.

As a matter of fact the E.E.G. is a very coarse and crude index of brain function. The simple waves observed can have only a very limited value in the ultimate analysis of the complexities of cerebral activity. This is emphasized by the lack of significant changes in the E.E.G. in many of the most severe mental diseases and also by the fact that brain waves from a guinea pig or a water beetle may show a striking resemblance to those obtained from the human brain.

In conclusion it should be added that the electroencephalogram is a valuable aid in the diagnosis of epilepsy and certain other brain lesions and diseases, but that it is not a substitute for an accurate history, careful astute observation of the patient, and good clinical judgment. It is only in the light of these that the E.E.G. gains significance and can be safely used in conjunction with other laboratory investigations to aid in the diagnosis and treatment of patients with nervous and mental disease.

Guilt and Anxiety as Social Controls

D. Ewen Cameron, M.D.

Before coming to grips with these topics, it is necessary to clear the ground — and clear our minds. For our predecessors made great use of anxiety and guilt in their thinking about human behavior. They used them to an exceptional degree as a driving force to turn the wheels of their social structure. They worked out ideas and beliefs about anxiety and guilt which were useful enough in their lives but which are now out of date and are muddling our thinking.

Each new group, as it takes over the scene from its predecessors — the Victorians, the Edwardians, those who lived through the first World War — has had this selfsame job of clearing away the wornout concepts, the used-up beliefs and the antiquated ideas left behind by those who occupied this uneasy earth before them.

When we come to consider this matter of the use of guilt and anxiety as social controls, the amount of clearing away that is necessary is quite prodigious because of the very fact mentioned above, namely, that those who went before us made such great use of them.

Let us start off by saying that social control is an essential of our survival. If we are to live together, then our actions — the actions of ourselves and of our neighbors — must be subject to control. For we are by nature expansionists, and aggressive expansionists at that. We seek continually to expand our mastery over our world — over the weather by building houses, over time and distance through the rapid development of our transportation systems, over our fellows in the endless rivalries and competition of the family, the office, and, in bloodier form, between national groups.

Fortunately we arrive in this rather difficult world with certain devices already built into our natures which greatly facilitate our capacity to establish social control. These devices are the capacity to feel pain, to feel anxiety, and to feel guilt.

The use of pain as a social control I shall dismiss briefly by saying that it is much less used than it was. True enough, the sound of the parental slipper is still heard at the bedtime hour, but not so much as formerly. The ecclesiastical rack and the torture chamber, once used to wrench the sinner back to the path of righteousness, have disappeared save for a brief and horrible revival under the Nazis.

We still use, and probably shall continue to use, anxiety and guilt for quite some time as social controls. We are using them, however, differently from the way in which our grandparents and great-grandparents wielded them. It is most important to define these differences since, oddly enough, although we use them differently there is still a hangover of our old ways of thinking about them.

At this point let me make some statements which our predecessors would not have made but which nonetheless are gaining increasing acceptance in our days.

The first statement is that ideas of right and wrong are not inborn. During the last several decades a flood of information has come to us from other cultures all around the world — information concerning the very different ways in which such matters as the bringing up of children, the dividing of property, the managing of marriage, and the administration of justice can be carried out. There was a time when we were prone to dismiss these as the ways of natives, savages, or simply foreigners. Now we recognize them as the different ways in which human beings have been able to work out their relationships with each other and have been able to solve some of the profoundly difficult problems of liv-

ing together. We can see very clearly that in their various settings these quite different ways of managing things operate fairly satisfactorily. They work well even though they may not be acceptable in our own culture, though they may be designated as "bad." Similarly, those things which are accepted in our culture are often considered "bad," "wrong," "not done," in others. For instance, the simple custom of eating in public is regarded as a matter of embarrassment and shame in Bali.

In a word, "good" and "bad" are relative, not absolute things. The great difference between the way in which those who lived before us thought about anxiety and guilt and the way in which we think about them is thrust into still sharper outline by the statement that they looked upon the excessively conscientious person, the person prone to feel guilty over every passing trifle, as someone who had a specially delicate sense of right and wrong and who for that reason was to be considered a specially worthy person. We, however, think of him as having a limited and crippled personality and as having been damaged most probably by unhealthy childhood experiences. Similarly, anxious-minded people we now know to be very rarely those people who are taking unnecessary risks and are more often people whose sense of security has been badly shaken by exposure to insecure people during their earlier years.

We are born with the capacity to feel anxiety and guilt. We are not born feeling guilty about anything. The things to which we may respond with feelings of guilt when we are twenty are things which we have been taught, during the intervening years, to feel guilty about. The same is very largely true about anxiety. When we are born we have a capacity to respond by anxiety, but there are only a few things, such as loud noises and the fear of falling, which seem to be inborn. All other fears and anxieties are acquired through the experiences we encounter in living. We have now come to the point where we recognize that we ourselves decide what things we are going to feel guilty or anxious about, and also how guilty and how anxious we are going to feel about those things. This represents a very radical departure from the thinking of our predecessors, who felt that these things were inborn, that they were part of the nature which man had been given, and that for this reason we should not attempt to do anything about them.

Now, having contrasted the old and the new ways of looking at anxiety and guilt, let us say that we still need these two things as social controls, though they are crude and clumsy. The essential difference is that from here on we are going to attempt to *use* them rather than think of them as being something preordained.

Perhaps we can see something of what we are likely to do in the future about anxiety and guilt if we look at what we have already done about pain. We have not tried to abolish the capacity of individuals to feel pain. To do so would be very hazardous indeed since we might suffer a great deal of damage if we were not capable of knowing that the cigarette was burning our fingers or that something was going wrong with our appendix. But we have tried to eliminate the causes of pain and we have tried to prevent pain from going on unnecessarily. As soon as it has drawn our attention to the fact that something is wrong, we try, through aspirin, codeine, or the general anesthetics, to protect the individual against too much suffering. Interestingly enough, this last step, though now so widely accepted, was not achieved without something of a struggle. Shortly after the general anesthetics were introduced, their use in childbirth was proposed. For a time this was stoutly resisted, on the grounds that it was "natural" for a woman to suffer pain at such times, and to interfere with it was to interfere with the ways of Providence. Fortunately this ancient idea has been forced into the retreat into which all such dogmata are being driven.

Now, if we look at anxiety, we will

see that we are already beginning to try to identify the causes of anxiety — the dangerously insecure people who as parents transmit their anxieties to their children through the unhealthy atmosphere which they create, the anxiety produced by the high-speed industrial job, by economic insecurity. Many of the old anxiety-producing ways of looking at things are disappearing. We no longer try to control our children by telling them ghost stories, we no longer talk about the "unforgivable," the "uncorrectable." The nineteenth century woman who was "irretrievably ruined," and the Kiplingesque character who was "beyond the pale" live now primarily in fiction.

It may be that we can eventually accomplish something of the same thing with guilt that we have done and are trying to do with respect to pain and anxiety. Our first step must be to recognize that although for a time we shall have to continue to use guilt and anxiety as ways of controlling ourselves and our neighbors, a great deal of damage is done by the ignorant manipulation of the anxiety and guilt feelings of people. To this one must add that some damage is not done in ignorance but is done through the deliberate fingering and manipulating of other people's feelings of guilt and anxiety for the profit of individuals and institutions.

Here is the kind of damage that can be done in ignorance by a mother who is herself prone to react to living by excessive guilt and excessive anxiety. A twenty-four-year-old girl comes to the psychiatrist saying that she feels inadequate, in the office, with her friends and, indeed, everywhere she goes. In particular she feels that she cannot make friends with boys, she is afraid of them. She has nothing to say when her girl friends begin to talk about dates and dances. We get a history, which she brings out with the utmost reluctance and with the strongest possible resistance, that from the age of four to eleven she had sexual adventures with a number of little boys. She went through these with apparently no more guilt feelings than she would have suffered in stealing cookies. At the age of eleven she told her mother what had happened. The latter responded explosively, with denunciations and, for a time, with complete rejection of the girl. She told her that what she had done had ruined her, that no one would ever have anything but contempt and loathing for her. She said that she could never trust her daughter again out of her sight, that the girl had no idea what men were like. From that time on, not unnaturally, the girl developed those fears and feelings of guilt in the presence of boys which now, at twenty-four, have entirely obliterated her capacity to enter into any friendships of even the most limited kind with men. Here, then, is the feeling of guilt and anxiety used as a means of social control to an excessive and extremely damaging extent.

Then again we find the feeling of guilt used by a mother who was deeply insecure herself and whose relations with others were pervaded by hostility. From the earliest years of her daughter's life this mother used criticism and the withholding of affection as a means of controlling the girl. To these the mother added the fostering of the girl's sense of guilt. The method is age-old and very well known. Whenever the child showed any tendency to rebel against her mother's continuous criticisms, the latter would respond by saying, "You don't appreciate what I am trying to do for you. I work day and night until I am so tired that I could drop. But you have none of the love that a daughter should have for her mother. You are an unnatural child." This was carried on to its logical conclusion where the mother told the little girl that her continual naughtiness was causing her mother so much worry that her heart was becoming affected and that she might die. When by chance the mother did fall sick from an attack of pneumonia, she used the occasion to say to the girl, "Look what you have done to me."

These things to the adult may look pretty small; they may seem things

that one could brush away pretty easily. But to the child whose mother and father are truly the yardsticks of his existence, they are tremendously important. The removal of the father or mother by death looms as a major catastrophe, and attitudes thus graven into the child are extremely hard to eradicate with the passing years. Consequently, when this girl reached her thirties, she still felt almost completely under the influence of her mother. She hardly dared feel hostility towards her mother's criticisms, because of the feelings of guilt which the latter had built up in her.

Eventually she came under treatment and very slowly began to recover. As her recovery became apparent her mother, however, felt increasingly threatened by the girl's emerging independence. Her critical attacks on her daughter increased and ultimately culminated in the vituperative cry, "You don't love me at all; you are only interested in my pocketbook." This was given spurious substance by the fact that the girl was so crippled by her guilt and anxiety feelings that she was unable to work and, therefore, had to depend upon her mother for financial support. Eventually the mother succeeded in her attacks and forced her daughter to break off treatment.

These are glimpses into the lives of real persons. It is easier for us to understand these great forces of anxiety and guilt in terms of people, but there is a time also to emphasize the universal nature and the tremendous potency of these forces. To realize this, and to realize at the same time to what extent our ideas about them are changing, is to realize that we are in the midst of a vast revolution of thought.

Save for a very few, it was generally believed up until the middle of the nineteenth century that man's social institutions, his systems of belief, were not really his own — they had been given to him, or, at any rate, they were there and he had to make the best use possible of them. If he could not make them work, that was his fault, it was a sign of some inherent weakness, of inborn sinfulness. Now all this is changing. We are beginning to recognize that our social institutions, our systems of belief, are our own inventions. If we invented them once then we can certainly invent and build up better ones. Most certainly a glance around the world would make us pretty sure that most of them could be improved.

In particular we have to be especially critical of those systems of belief, those social institutions, which make excessive use of anxiety and guilt to control people. In these decades when extremely difficult decisions have to be made we cannot afford to have our children growing up with minds blocked off by guilt feelings, growing up to be people who say, "You must not talk about such things," "That's not something which can be discussed." We cannot afford to have our children coming to adult years so anxious-minded that they cannot decide for themselves but must have others make their decisions for them. That is the road to totalitarianism, whether the system of belief on which you must depend belongs to the Right or to the Left. The Right and the Left do not really represent choices; they are the same thing. The choice is between them and freedom — freedom from unnecessary anxieties and guilts, freedom from taboos and useless prohibitions, freedom from all kinds of crippling social institutions.

Preview

We have heard of so many seeming miracles wrought by the use of penicillin. What effect does it have on syphilis? The latest word on the treatment of this disease will be featured next month under the authorship of **Dr. B. D. B. Layton** who is chief of the Division of Venereal Disease Control in the Department of National Health and Welfare.

Psychiatry in the General Nursing Field

MILDRED NELSON

AT THE CLOSE of the year 1943* there were in Canada 59 institutions for the care of the mentally ill with a total of 46,631 patients, an increase of 1.4 per cent over the previous year. For a ten-year period the increase had been gradual and consistent with no decrease at any time. The cost per capita was $407 per year, making a grand total of $19,199,206. This represents the cost to the state for the care of the patients who are actually mentally ill. But, besides this, if we consider the loss to the patient in salary, the cost to the state in caring for the dependents of those mentally ill, and then add to this the cost of caring for those who are still able to carry on in the community but who are not self-sustaining we would have to multiply the cost many times.

Other interesting figures have been worked out, such as, that the patients in hospitals for the mentally ill are more numerous than for all other types of hospitals combined; the number of mentally disordered individuals closely approximates the number of persons in colleges and universities. Other statistics show that one child in each group of twenty boys and girls now fifteen years of age will be sent at some time during his life to a hospital for mental diseases to spend an average of over seven years there. At the age of fifteen, the chance that such illness will develop later in life is one in twenty.

Besides the large number of patients in mental hospitals, we have in the school, in the clinic, in the doctor's office, in the general hospital, and in the community, problems of great psychiatric significance although this may not be apparent to the casual observer. The field of nursing has expanded—it is no longer merely bedside nursing in a general hospital ward or private duty in the hospital or home. Nursing today is a community service, and the functions of the nurse may be summarized and briefly stated:

1. *Care of the sick:* Care of the sick in the modern sense means care of the individual—care of a total personality—not the care of physical illness alone.
2. *Prevention of disease:* This includes prevention of both physical and mental illness—the practice of preventive medicine.
3. *Health education:* This is the most recently added function of the nurse and the one that is receiving considerable attention and stress at the present time.

In retrospect we can see that great strides have been made in the care of the mentally ill. We read of patients formerly being lodged in dungeons, chained, beaten, starved, and even exhibited like wild beasts for the entertainment of the public upon payment of an admission fee. The publication of the book by Clifford C. Beers, "A Mind that Found Itself," aroused much interest and provided considerable stimulus for the advancement of this work. To this book and the interest aroused we attribute the origin of the Mental Hygiene Movement, started in 1907. This movement was originally started to ameliorate conditions in asylums—as mental hospitals were then called—and to prevent development of mental illness in adults. From this beginning, interest was redirected and attention turned to juvenile delinquency, behavior problems of school children and, more recently, to preschool children, stress being placed on activity and adjustment.

Hygiene may be expressed simply as the science of keeping well. Until the dawn of the present century keeping well meant keeping physically well. Today when we speak of keeping well we include both mental and physical health. The trend has been from curative to preventive medical science. With mental illness the recent trend has been to a preventive

* Dominion Bureau of Statistics, 1943.

science known as "Mental Hygiene" which may appropriately be called the latest development in medicine. Muse has said that "Mental hygiene may be thought of as the psychological branch of preventive medicine, and no phase of the art of healing can afford to neglect it."

Because of the interest shown in those committed to institutions for the care of the mentally ill, some have the misconception that mental hygiene is concerned only with the more serious disorders. This is not the case. The practice of mental hygiene may be divided into two parts:

1. Positive guidance of the ordinary course of life so as to promote desirable traits of personality and to avoid causing maladjustment. Each person has an effect on those about him—it may be favorable or unfavorable but it affects his adjustment. The practice of positive and constructive mental hygiene is not limited to any one professional group but is a common social duty.

2. The other concept of mental hygiene is the study and treatment of those already maladjusted, that is psychiatry.

It can readily be seen that mental hygiene has a very broad field. L. D. Shaffer says, "The practice of mental hygiene is not limited to the work of the clinics or the treatment of the maladjusted. In a very real sense, everyone is engaged in mental hygiene whether he intends it or not. Preventive action in mental hygiene is of more fundamental importance than is remedial to repair damages already done. If all persons who deal with others, especially parents, teachers, and employers, governed their influence by principles of mental hygiene, there would be fewer lame and deficient personalities for clinicians to treat. The constructive measures that are applied to create effective personality have been termed positive mental hygiene." To reiterate, "Everyone is engaged in mental hygiene whether he intends it or not." The layman does not treat physical illness but must know how to recognize early symptoms and seek expert advice. In mental illness, the importance of early recognition and early treatment cannot be too highly stressed.

In considering the universal application of mental hygiene—"Every member of society has a responsibility for the promotion of good mental hygiene." From the very nature of education, the school assists the child in his adjustment to society, but his adjustment must be flexible and progressive. The child must not only make a temporary adjustment but must acquire the ability for readjustment. From the standpoint of society, the schools in a democratic state such as Canada hope to develop citizens able to play their part in a democratic state, and to make new adjustments in a changing and progressive social order, so that social stability may be united with social progress. From the point of view of the individual the schools exist to aid him in his own growth, in making adjustments to his environment which is both a social and physical environment, resulting in the development of an integrated personality, socially efficient, capable of further growth and development, capable of critical thinking, of open-mindedness and freedom from prejudice, unimpeded by unregulated emotion. Education is continuous throughout life; it means progressive change for progressive living. It is the task of the school to make things intelligible by presenting principles of science in a simplified setting. Subject matter is not educative in and of itself, but only as it is made meaningful to the pupil.

Health, including mental and physical health, is the first objective of education. The pupil should achieve health by living a healthful life and by building up a sound system of health habits. These habits should be strengthened by growing knowledge and developing attitudes and ideals. The outcome of the study of health may, therefore, be classified as health knowledge, health habits, health attitudes, and health ideals.

In recent years mental hygiene has come to permeate our whole educational system and it has a place

in every curriculum. The purposes of mental hygiene as expressed for Grades I and II are:

1. Be happy and cheerful at home and at play.
2. Practise self-control and self-reliance.
3. Have a sense of fairness in play and games.
4. Overcome unnecessary fears.
5. Cultivate kindness to playmates and animals.
6. Learn obedience.

These principles are enlarged upon as the pupil progresses in his studies. By the time he has reached Grade VI the aim of the mental hygiene program is to develop the idea, "A sound mind must have its home in a sound body," and to develop the motto, "What I am to be I am now becoming." Mental hygiene has its foundation in the most elementary education but it does not end there. It is included in the courses and curricula of higher education—for various professional groups, including social workers, teachers, medical students, psychologists, and theological students.

Mental hygiene has been included in the educational programs of many professional groups and it is generally conceded that mental hygiene should be included in the education of the professional nurse. However, at the present time, mental hygiene is a recommended not a compulsory course in our curriculum. In the "Survey of Nursing Education in Canada," published in 1932, Dr. Weir stated, from evidence of questionnaires answered by nurses, that "Psychology applied should receive about 90 per cent more emphasis; that it should not be 'bookish,' but should be based upon the observation and analysis of human problems and actual situations."

Following the publication of the Survey, leaders in nursing education in Canada concerned themselves with compiling a curriculum that they thought would be workable for experimental application throughout Canada. The Proposed Curriculum emphasized mental hygiene throughout the entire course. To begin with, the aim of nursing education was stated as: "The philosophy underlying nursing education should be in harmony with those educational principles which make for the fullest personal, social, and professional development of the individual." To quote further: "The nurse, probably more than any other professional worker, comes in contact with a great variety of life situations, and it is the responsibility of nurse educators to develop in the student those personal and professional qualities which will enable her to make her greatest contribution to public welfare. She should be capable of viewing situations objectively and, by the intelligent application of general principles, be able to pursue a course of action based on sound reasoning and careful planning. Because of this ability to make the necessary adaptations she is able to assist in bringing about those changes which, in the light of her best judgment, would seem to contribute to the welfare of the community." Because of the part the nurse is expected to play in the community it is only proper that this should be considered in choosing the subject matter to be included in the curriculum of the schools of nursing. Mental hygiene can not be considered an entity in itself. It can never be isolated from other subject matter. It is dependent upon others for a fuller appreciation of its application. The two subjects most commonly considered as closely related to mental hygiene are psychology and psychiatry.

Psychology may be defined as the study of the workings of the mind. Each one is influenced by his environment and this is very important to the student nurse. It enables her to study herself and aids her in making a satisfactory adjustment. It also helps her to assist her patients in making satisfactory adjustment. In no other profession is the student called upon to make so much adjustment. Sometimes the process has been so simple that one is hardly aware of a change; at other times it has involved a conscious adaptation—absence from

home, dormitory life, differences in routine of personal habits, even the differences in food. Other things to which the student will have to adjust include hospital environment and an intimate contact with sick people of all races, creeds, and stations in life. At the same time she begins an association with the various members of a large institution, the nursing and medical staff, and with visitors.

At a later stage in her education the student nurse studies psychiatry, the care and treatment of the mentally ill. No attempt is made to train specialists but the course should be so arranged as to give her a better understanding of the mentally ill, and a broader appreciation of the principles of mental hygiene. By contact with the mentally ill, those who are marked examples of maladjustment, she is better able to understand slight maladjustment and it will give her a better understanding of the prodromal signs. Clinical experience in psychiatry will be very valuable in that it increases the nurse's tact, tolerance, her understanding of mental illness and of her patients individually. It increases her power of observation and puts her in a position to correct the many prevalent but mistaken ideas regarding mental illness and mental hospitals.

In closing, I shall refer once again to the functions of the nurse: the care of the sick, both those mentally ill and those physically ill; the prevention of disease, both mental and physical illness; and, finally, health education which includes the principles of mental hygiene. We cannot separate mental and physical illness. Each illness presents its emotional and psychological aspects which are too frequently ignored because the nurse is unable to cope with them due to her lack of instruction and experience in psychiatry.

Psychiatric Affiliation

ELLA G. SMITH

IT HAS BEEN the concern for years of the Medical Psychiatric Association to find competent trained personnel to provide nursing care for the mentally ill. Research in psychiatry has made rapid strides in the advancement of psychosomatic medicine. Yet, the preparation of personnel to make the necessary application to the clinical field has lagged. For years much discussion has taken place regarding a well-rounded program of nurse education, yet, while preaching this doctrine, year after year hundreds of nurses have been graduated from schools of nursing without having had any experience in the field of psychiatric nursing.

It is startling to note that many of the nurses in this specialized field have been absorbed in other fields of nursing. Much credit is due the nurses that have remained and endeavored to keep up the standard of nursing for the mentally ill patient. These nurses find that no greater satisfaction can be obtained than watching a diseased mind return to normal and the patient restored to health, returning to the community to carry on at his or her prepsychotic level.

For the future of mental nursing it was decided to do something to interest nurses in this specialized field. The Registered Nurses Association of Ontario allotted one-half day of the annual convention to a mental hygiene program. This afforded an opportunity to present to the nurses the need for psychiatric training in the basic course of every student nurse. The inspector of Training Schools aroused enthusiasm about such a course during her visits to the various hospitals in the province. As a result, a conference was held to consider the

possibilities of an affiliation. Superintendents of nurses were present from eleven general hospitals and a discussion and outline of the course was presented by the members of the Ontario Hospital staff. The interest kindled resulted in twenty applicants, from seven schools of nursing, in the first class.

The aim of psychiatric experience in the basic course is to acquaint the student nurse with a working knowledge of human behavior, both normal and abnormal, and to give her knowledge of psychiatric nursing. This experience matures the nurse herself and gives her better insight into her personal problems as well as the problems of her patients. She learns to recognize early symptoms of mental disease and becomes more interested in the psychoneurotic patient, resulting in an endeavor to get at the basis of his illness.

The three months' course includes classroom teaching of the following courses: Psychiatry, 12-15 hours; Mental Hygiene, including general and childhood, 15-20 hours; Psychiatric Nursing Problems, including charting, ward problems peculiar to this hospital, 4 hours; History of Psychiatry, 4 hours; Occupational Therapy, 11 hours, consisting of 2 hours' theory and 9 hours in craft work, learning the art of hemstitching, knitting, leathertooling, and basketry; Neurophysiology and Endocrinology, 10 hours; Hydrotherapy, 6 hours. Special lectures include such topics as legal admissions to mental hospitals, hazards in mental hospitals, special treatment for neurosyphilis, etc. Ward clinics number from 10 to 20 hours and include orientation, drug therapy, problems and routines peculiar to ward, fire drill, occupational and psychotherapy for patients, history and classification of patients. Morning circles are conducted by the supervisors, reviewing the ward problems and nursing procedures. Nursing care clinics are conducted on the wards totalling ten or more by the instructors on psychoses peculiar to that particular ward. The student may assist or conduct this clinic under supervision. This enables the classroom instructor to correlate classroom teaching with ward practice. A seminar is conducted at the completion of the course when the set-up for the care of the mentally ill in the province is reviewed. In addition to this teaching the student is expected to complete a behavior study, a symptom record, a personality study, and a nursing care study. After these assignments have been evaluated, an informal conference is held with the student, instructor, and superintendent of nurses. At this time there is an opportunity to determine the student's grasp of her subject and to find out her appreciation of the course as a part of her undergraduate studies. Comments made by the students are of interest:

(a) A course in psychiatry should be included in every nurse's course. I believe it should be part of the training in the general hospital because it gives a nurse a different viewpoint on mental illness. It prepares the nurse to meet the general public.

(b) I believe that the course in psychiatry will prove exceedingly beneficial—first, because it has given me greater insight into mental illness and, second, because I am not frightened by the patients or the idea of mental illness. I had never realized that the patients might walk about the wards at will and in a very pleasing environment. I understand how mental illness and physical illness have a bearing one on the other. Now I realize the importance of good mental hygiene, not only in my own life but also in the life of my friends and patients. The course has enabled me to analyze my own feelings in a more definite manner than before.

(c) I feel that now I know why patients become disturbed and also that they are not as violent as I had been led to believe.

(d) Psychotherapy, which is essential in psychiatric nursing care, could be adapted equally well to patients in a general hospital.

(e) I soon realized after visiting Ward One that there were many patients whom one would not necessarily recognize as mentally ill. The general atmosphere amazed me—for example, a piano, a radio, rugs on the floor, drapes on the windows, and flowers in the corridor. I was quite impressed with the Occupational Studio and the parties held there for the patients. For example, the Hallowe'en

costumes which were made by the patients were unusual. The craft work, knitting, and sewing assignments were outstanding and I feel this diversion could be applied in general hospitals, especially during the convalescent period of the patient.

(f) The case study assignment for the student is very beneficial. I really learned the mental disease from which the patient was suffering, and I found I was able to recognize symptoms.

(g) Through my training and experience in this course, I have learned how I may cope with the neurotic patient in general hospitals. I shall attempt to divert their attention from their complaints and introduce occupational therapy. Through this course one can make more suggestions along this line. I feel hydrotherapy might be carried out in general hospitals and thus reduce chemical therapy.

The student attends four psychiatric conferences during the course. At the consultation will be the medical superintendent, the staff doctors, the internes, the Mental Health Clinic psychiatrist and the psychologist. The history and illness of the patient is reviewed and discussed and then he or she is brought to the conference room. He is interviewed by his doctor and is then returned to his ward. Following this interview there is further discussion and the patient is then classified. This teaching enables the student to determine the cause of mental illness and the probable prognosis.

The students rotate from one service to another. This includes four weeks on the female admission floor, one week on the male admission floor, three weeks on the acute mentally ill ward, three weeks on the senile patients' ward, and one week on the continued treatment patient ward with experience in the occupational therapy studio. The nurse spends three days in the Mental Health Clinic where she observes home visits and outside clinics with the psychiatrist, the psychologist, or the social worker. This introduces her to the preventive aspect and the follow-up work in the community. The clinic provides this service for the area that the hospital provides nursing care.

The nursing care of the psychiatric patient is not heavy physically. A definite routine is necessary as a protection for the patient and hospital. The nurse has to learn the psychology of approach to patients. By winning their confidence and persuading them to assist with ward duties, she breaks through disturbed thoughts and directs their activity into normal channels. The value of psychotherapy and occupational therapy is realized. Psychotherapy is the scientifically directed influence of one mind on another in the interest of health. It may be any procedure such as suggestion or persuasion promoting encouragement and assisting with obtaining self-confidence. It could be anything from a pat on the back to an elaborate mental analysis. It is sometimes called mind cure or faith cure. Occupational therapy is also considered a treatment, just as quinine is a treatment for malaria. It is any activity, either mental or physical definitely prescribed by the physician and guided for the purpose of hastening recovery from disease or injury. It is a therapeutic stepping-stone which aims at: first, recovery of patient; second, adapting a patient to some department or phase of institutional life; third, returning the patient to society.

The student works an eight-hour day and a forty-eight hour week. Nght duty is not assigned as there are fewer educational opportunities in this period. Class hours are included in "duty time."

The final grade received by each student is calculated by the score received on assignments and final examinations. A record is sent to the home school which lists grades in theory and practice as well as a brief narrative summation of the student's adaptability, etc. The incoming record, showing the student's physical record, etc., is kept at the affiliating school.

The thirteen weeks in a mental hospital will do more than introduce the student to mental nursing. It helps her to recognize personality problems within herself, her family, her friends, and her patients. She

will be more tolerant, more tactful, more observant, and better able to adjust to life situations.

The student has the benefit derived from associating with nurses from other schools of nursing and she has to learn to adjust to a new situation where policies are different—for example, the nursing care for the up-patient. She learns that cleanliness, both externally and internally, is as important for this patient as for her bed patient. It requires more teaching, supervision, and close observation, thus better qualifying her for her health teaching program. She learns the therapeutic value of beautifully landscaped grounds in the convalescent care of the patient. The social life of the student is not forgotten. There are many seasonal sports such as tennis, lawn bowling, swimming, boating, skating, curling.

The affiliation courses that have been completed at the Ontario Hospital, Kingston, have been most gratifying, mainly because of the manner in which the students adjusted and became interested in the psychiatric patient. It is believed that psychosomatic medicine is so permeating the picture that the nurse and the physician of the future cannot afford to be without this preparation.

Is Cancer Increasing?

PHYLLIS MCPHERSON

OVER THE PAST THIRTY YEARS, the study of cancer has become more and more intensive. No solution to the cause or prevention of the disease has yet been found, but through this intensive study an accumulation of enlightening facts has been gathered which gives a clear picture of cancer incidence in Canada, its prevalence by sex and in various sites, and its relative mortality rating with other diseases.

In 1941 in this country, cancer killed 6,771 males and 6,646 females—seemingly more men than women. However, in proportion to population figures in the Dominion of Canada of 5,900,536 men and 5,606,119 women, cancer deaths were actually higher among women, being 114.7 per 100,000 of the male and 118.5 per 100,000 of the female population.

As a cause of death, cancer is Canada's No. 2 killer, second only to diseases of the heart. Its rating with other leading fatal diseases in 1941 was 13,417 deaths to 26,602 from heart diseases, and a considerably lesser number of 6,072 from tuberculosis, 5,955 from pneumonia, 2,411 from influenza, and 2,140 from diabetes.

This figure of 13,417 cancer deaths in 1941 was an increase over the 1936 census figure of 11,694 in cancer mortality—1,723 more deaths per annum after a five-year period. Here again, however, this appalling increase in fatalities is counter-balanced by a relative growth in population — close to 500,000.

A greater incidence of the disease is also apparent through diagnosis. Many cancer cases in the past were never known to be such. Facilities for accurate diagnosis of certain types of cancer had not been discovered, or perfected to such an extent that they could be relied upon definitely to diagnose cancer beyond question. And, where a margin of doubt existed the case was not reported as "cancer." Internal cancer was, until recent years, extremely difficult to diagnose. The symptoms, as told by the patient to his doctor, were in most cases similar to various other ailments — stomach ulcers, hemorrhoids, or various other aches and pains or manifestations of ill-health. But the doctor needed x-rays and barium fluid to be able to say "there is a tumour." He needed a biopsy to say "it is malignant."

Cancer strikes the aged. Through cures and more effective measures developed in the treatment of other diseases, a greater number of people are attaining an age when cancer is likely to arise. Approximately two-fifths of cancer deaths occur after the age of seventy. More people are living to this age. Since 1900 the overall death rate between the ages thirty to forty has been reduced by about one-half, from forty to fifty by a third, and over fifty years of age there has been no noticeable reduction. Progress along these lines has been greatest in the infectious disease group; with the lowered mortality rate from infectious diseases, more and more people live ultimately to develop cancer. So, cancer remains a killer. Is it any greater killer than it ever was? Or have improved diagnostic facilities, and increased longevity merely inflated the figures?

Foot Care and Exercise

Take care of your feet because they are your means of getting around. As a first-aid to tired feet, a foot-bath should be a must in before-bed routines. Warm water, plenty of soap lather worked up with a hand brush, followed by a cold plunge or spray will remove the day's accumulation of dirt, perspiration, and dead skin that forms on the feet.

Toenails should be brushed briskly and an orangewood stick should be used on them. A wet pumice stone rubbed over the softened corns and callouses will ensure comfort. A piece of moleskin or a felt ring properly placed retards the regrowth of these annoying excrescences. Use of razor blades on the feet is always dangerous.

The following exercises, if performed exactly as outlined, can be of great benefit in strengthening weakened muscles and in rejuvenating feet suffering from fatigue. Choose one or two which you can do comfortably and do them every morning first thing out of bed. Three minutes at most is all the time you need. At the start do each exercise five times. As your feet become more proficient increase the number of movements until you can comfortably do each exercise twenty-five times.

To strengthen foot and leg muscles: Place two chairs close together. Sit on one with your legs extended over the other so that the heels are free and the feet are about twelve inches apart. The following motions are performed with the feet only, the legs being held perfectly still: (1) Bring the feet up. (2) Curl the toes down. (3) Push the feet down. (4) Turn feet inward attempting to touch soles together. (5) Pull feet well back holding for a few seconds, and then start all over again with No. 1.

To strengthen the muscles supporting the arch: Take the same position as in the previous exercise. Turn feet inward, making the soles touch. Hold for a count of five, then relax.

To benefit the metatarsal arch: Stand on a large book with toes extended over the edge. Pull the toes down attempting to touch the side of the book with the underside of the toes. Hold for a count of three. Relax. The picking up of small objects with the toes is another useful exercise.

For fatigue and pain in calf and knee due to muscular tension: Stand shoeless with feet parallel and body erect, facing a wall. Place hands on wall at shoulder height and allow the erect body to approach the wall slowly, making certain the heels remain on the ground. Hold for a count of five. If properly done, tension will be felt at the calves. Increasing the distance between yourself and the wall increases the severity of this exercise.

—*Health News*

Preview

While most mothers try to teach their daughters to be good housekeepers, many nurses who find themselves in the role of superintendent in our smaller hospitals feel somewhat overwhelmed by the multiplicity of housekeeping details for which they become responsible. **Elizabeth A. Pearston** has come to your assistance with some very concrete suggestions which will help you over many rough spots.

Contributed by the Committee on Institutional Nursing of the Canadian Nurses' Association

Teaching and Learning in Schools of Nursing

S. R. Laycock, Ph.D.

Those who are responsible for training student nurses in schools of nursing have to concern themselves with four major problems: (1) the curriculum; (2) the readiness of student nurses to profit by instruction and training; (3) the facilities available for learning; and (4) the methods of instruction used.

The Curriculum

Those responsible for the curriculum in a school of nursing are faced with the same problem as are any curriculum-makers. A curriculum is a *selected* body of knowledge, skills, and attitudes which are considered the *most* important for the pupils concerned. There are thousands of things which might be taught to nurses. From these the curriculum-maker has to make selections. Everything put into a curriculum is there at the expense of something else left out. If you teach this you cannot teach that. It is vital, therefore, that the curricula material used in a school of nursing should be carefully chosen as that which is *best* calculated to turn out high-grade nurses.

It is not the purpose of this article to discuss curricula in schools of nursing. The layman, however, often wonders about the number of new subjects which the student nurse has to begin all at once—anatomy, physiology, bacteriology, drugs and solutions, practical nursing, personal hygiene, etc. If a student nurse has all of these subjects during the first four months of her course while she is making a major adjustment to a whole new way of life, the result may well be mental confusion.

Student Readiness for Instruction

Every instructor in a school of nursing has to consider the question of the readiness of her pupils for instruction. In spite of insisting upon a high school diploma for entrance to schools of nursing there is a wide range in intelligence—that is, in capacity for doing relational thinking—among those who gain admission. Some will, of course, have to be weeded out. As for the rest, the instructor must be able to adapt her teaching to their needs. This means that while pupils are taught in classes the instructor must nevertheless be aware of the individual needs of the students and adapt her instruction accordingly.

In spite of the high school diploma, student nurses exhibit a wide range in the knowledge and skills they bring with them to a school of nursing. Very important among these skills is the ability to read with speed and comprehension. Many students who graduate from high schools read with the comprehension and speed of the average Grade IV pupil. If such students enter a school of nursing they are greatly handicapped in carrying out the study required of

them. Student nurses also bring to their training-period a wide divergence in their ability to study efficiently. Educators find the techniques used in study of increasing importance in students' success in professional schools.

Then there is the question of differences among the student nurses in emotional, social, and intellectual maturity. There is increasing evidence that the nursing profession is for adults only—that is, for those individuals who have grown up emotionally, socially, and intellectually as well as physically. Among the qualities important for the student nurse are being able to bear tension without blowing up, to become emotionally weaned from home and parents, to observe the ordinary amenities of life and to have friends among one's age-mates, to make up one's own mind, to keep an open mind until all the evidence is in, to take responsibility for oneself and others, to face one's limitations and to come to a working compromise with life. The score of the student nurse on these and other traits is an index of whether or not she is a good risk for the nursing profession.

Facilities for Learning

The first facility for student nurses is that of time. The layman is always puzzled how student nurses who work as much as forty-eight hours a week and often take lectures outside of that period can find the time or energy for serious study. Lack of time for study is a real handicap in training student nurses. There is the question of place, too. It is reported to be still true that some student nurses must do their studying without having an individual desk, reading lamp, and chair. The physical conditions under which study takes place are important for anyone —including student nurses.

Schools of nursing should provide their students with adequate library facilities where books and other supplementary material, including film and other visual aids to study, could be made available.

Finally schools of nursing could profit by giving their student nurses laboratory periods in *how* to study so that they might overcome the handicaps in their methods. Merely *telling* students how to study better is not enough. Rather, they need practice in studying under guidance.

Methods of Instruction

The ideal class in any type of school is a co-operative group where teachers and pupils together are thinking through a topic or practising a skill. The greatest sin of teachers is that they *talk too much*. They pour information over students like syrup over pancakes. There is too much teacher-activity. Thinking through a topic together where the student is continually challenged to think is the essence of good teaching. The straight lecture method should gradually pass out of use. There is an old saying that "a *telling* teacher is not a *telling* teacher." Most factual information is contained in textbooks. Instructors should not merely repeat this. Rather they should use the class period to help the student organize the data in the textbooks and to find new and richer meanings and applications in it. Good teaching is the *two-way* sharing of experience in which the instructor shares her experiences with the students and they in turn share theirs with the teacher and each other. The net result is a meaningful learning—learning which is not parrot-like memorization but learning which functions in the life of the student.

The instructor must have a clear-cut awareness of the aim of the lesson. She must know just what new knowledge, understanding, and skill she desires the student nurses to acquire. The purpose of each lesson should stand out clearly in the instructor's mind. One is not likely, except by chance, to hit something not aimed at.

Every instructor of nurses should try to evaluate the results of the class period. She should accept the motto, "If the learner hasn't learned the teacher hasn't taught." She should know, at the end of each lesson, just *who* has learned *what*. Every good teacher can, to a large extent, do this.

She accomplishes this by watching the reactions of every student, testing them by questions, and evaluating their grasp of the material by their participation in the discussion. No good teacher merely "casts bread upon the waters," hoping it will return after many days. Rather she tries to judge just what knowledge or skill was gained by Mary Jones, Jean Brown, and Betty Smith.

While the teacher must treat each student in her class as an individual she should not teach one student while all the rest do nothing. Rather she must use the difficulty of one student as a means of teaching *all* the class. When the instructor asks one student a question, there is a danger that the rest will relax and await their turn. The challenge of the question should be thrown out to the whole class first and then one pupil stimulated to answer to *all* the class, not merely to the teacher. Students should be encouraged to evaluate one another's answers. In addition, when a student has a difficulty, the teacher should see to it that it is the whole group—fellow students and teacher—who help to set her straight. If the class is really a co-operative group there will be no difficulty in doing this. Too much time in class is wasted by teaching one pupil at a time. A class is not a series of one-to-one relationships between teacher and students. It is a net-work of relationships in which the teacher becomes a guide to learning rather than a dictator.

What about dictating notes or having pupils copy notes? This is a vicious practice. Often it is merely a means whereby the notes in the instructor's notebook are transferred to the notebook of the student without passing through the head of either. The only notes that have any vitality are those which are "the minutes of the meeting" of the co-operative-group class. The instructor is the secretary-chairman of the group and as the latter thinks through a problem in organized fashion under her direction she writes down the finding of the discussion. These should not be copied down as the group goes along. Rather the members should be busy thinking. Before the close of the period, time should be given to copy down the results of the organized thinking of teacher and students. Notes which are simply superimposed on students usually have little real meaning to them. It would be better to have such notes mimeographed and given to the students. They could then be used as a basis for explanation and discussion.

Good teachers do not ask questions the answer to which is obvious. Nor do they ask questions in which the student has a fifty-fifty chance of guessing the right answer by saying "yes" or "no." Good questions stimulate thought. They should be clear-cut and definite. Instructors should always accept answers with courtesy whether they are exactly what they wanted or not. Otherwise students will be hesitant to answer next time. All students should be challenged by the question—not merely the bright ones, nor those who sit in front, nor those who put up their hands. It is a way of keeping the group co-operative—a way of bringing everybody into the discussion.

Too much teaching in schools of nursing is on a deductive basis—that is, the principle is given first and then examples are given afterwards. In up-to-date education in schools, great attention is now being given to *inductive teaching* where a pupil is given a number of particulars and then is led to formulate the rule himself. No longer is he told that there are three kinds of sentences—assertive, interrogative, and imperative—and then given examples of each. Rather he examines a large number of sentences to find what they do, groups them in classes and finds a name to express what they do. All good teachers, including good instructors in schools of nursing, are finding that leading pupils to formulate rules *after* they have examined particular instances is a much more vital method of teaching in many cases than the old method of first giving rules and then examples.

All good teachers are becoming

alert to the great help they may receive from the adequate use of audiovisual aids in teaching—pictures, diagrams, models, films, phonograph records, and radio programs. There is an increasing number of films which should be of use to instructors in nursing. Good instructors will be quick to take advantage of these. They should seek the co-operation of the Department of Education in their own province. In addition, they should write to Associated Screen News at either Montreal or Toronto for a catalogue of films and explain the type of films in which they are interested. Films can be secured on a rental basis. The Ryerson Press Film Service, of Toronto, and the Film Division, Department of Extension, University of Alberta, Edmonton, are also potential sources of help. Models, pictures, diagrams, maps, charts, books, pamphlets, and phonograph records should also be used extensively. The instructor should remember that these are *teaching-aids*. They are not a substitute for the teacher. They are not black magic. Their value depends solely on how they are used. To be of maximum service they must be prepared for and followed up by stimulating teaching. Every teaching aid should be judged by the standard of the extent to which it makes clear to the learner what to learn, how to learn, and why the material or skill should be learned.

The good instructor provides for review and drill. No one learns difficult material without some systematic review and practice. The first review of material should be within forty-eight hours since we forget a large part of what we are going to forget within that period, then a review in one week, three weeks, two months, and six months. Drill is important too. It does not need to be dull or boring if carried out in a snappy and interesting manner.

Finally, the good teacher knows that learning is specific—that one learns to do by doing and that one learns what one practises. Definite practice must be given in using the knowledge and skills that are deemed necessary. Moreover, just because learning *is* specific the instructor must *specifically* develop such generalized habits as dependability, loyalty, tolerance, cool-headedness in emergencies, and thinking through problems in an organized way. Modern educators do not believe there is much *automatic* transfer from one situation to another. As a result they recommend that nurses-in-training be given specific practice in as many types of nursing situations as possible and that, in addition, they be given specific training in the use of general principles which they will need to apply in unforeseen situations.

To develop a high professional standard in nurses there must be a high quality of teaching and learning in the schools of nursing. To achieve this is the aim of every good administrator and good instructor in such schools. To that end every bit of knowledge known to modern psychology and to the general field of education should be put into practice in these schools.

Receive Award

Three collaborating authors of the University of Minnesota won the first award of $1,000 in a national contest sponsored by the McGraw-Hill Book Company for the most outstanding nursing books submitted to them before September 20, 1946. The authors were H. Phoebe Gordon, assistant to the director of the school of nursing at the University; Katharine J. Densford, R.N., director of the school of nursing and president of the American Nurses' Association; and Edmund G. Williamson, dean of students. Their book, "Counseling Programs in Schools of Nursing," is scheduled for publication in May.

PUBLIC HEALTH NURSING

Contributed by the Committee on Public Health Nursing of the Canadian Nurses' Association

"Before They See the Light of Day"

ALICE G. NICOLLE, B.S.

HEALTH SERVICE for the child which begins when he enters school is six years too late.

In Ontario, as in many other places, most of our public health programs started with the school health service. To these pioneers we owe much for, in many instances, it is due to their efforts that communities have become increasingly aware that, beginning either to consider the child's health or to teach health habits when he comes to school is too late. School health service has demonstrated its value to the child. It has, however, also proved through the findings of physicians and public health nurses that many of the defects and difficulties of adjustment could have been prevented if discovered and corrected in the early years, long before the child reached school age.

The necessity of preparation for school has been seen for many years by public health physicians and nurses and certain teachers as an insistent need of every child. The summer round-up was an effort to meet the need, and much good work was accomplished by correcting certain physical defects which might have delayed the child's progress in school. Preparation for any new adventure in life is, however, much more than the correction of physical defects. It implies a gradual building of habits, ways of behaving and thinking in order to meet the new situation with a reasonable degree of success and happiness. With the young child this can only be achieved by opportunities for healthful living and patient guidance from birth till he goes to school. Entering school in itself requires of the child a great re-adjustment of his daily life. From the familiar surroundings of his home and neighborhood—the almost predictable behavior of his family, his routine of eating, sleeping, and the freedom of play—he suddenly rises early one morning to go to school.

School he finds has a teacher, who, however understanding, is usually a total stranger. Many, if not all, of the children are also strangers. He must conform to a pattern of work which is entirely new, although it may also be interesting. And last but not least, unless he is fortunate enough to live near a kindergarten, he must give up his freedom of movement as well as speech, for even his chair and desk may be attached to the floor. It is often at this time that he has his first health examination, his first immunization, and existing defects are recommended for correction. The wonder is that children progress as well as they do, when one considers the many new and not always pleasant experiences to which they are subjected in their first year of school. Then at best we have wasted six years of learning, not only for the child but for his parents. Yet, we say

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education begins at birth, and his parents are his teachers; at the same time our educational system implies preparation for teaching. Where shall parents secure this preparation for parenthood? It would be interesting and, no doubt, enlightening to gather information from elementary school teachers on the difference in general health, reaction to new situations, and learning capacity among children who have had adequate health supervision from birth, as compared with children who have not had the benefit of this health supervision. Still we have reason to be encouraged, for parents and other citizens interested in the welfare of children are seeking this continuous health supervision for each child from the time of his birth.

During a County Council meeting called to consider the establishment of a county school health program, a lively discussion took place on the health needs of the school child, the limitation of the school health program, and the child's need to be prepared for school that he might benefit from the educational opportunity it offers. A board member, an elderly gentleman of experience, showed great interest in the discussion and came to this conclusion: the preschool children for whom the school service does not provide will next year be school children. The value of preparation for school is obvious. Should we not go back further and have a community health service which provides supervision, even before they see the light of day? This rural board member is right. The care of the school child must begin before he is born, with the education of his parents and the care of his mother during the prenatal period. Although prenatal care is provided by the family physician, the public health nurse in a generalized public health program is prepared to supplement this service as an opportunity for family health teaching and the preparation of the home for the young child. (For whatever a child learns of health elsewhere, he can practise at home only what the home will allow or the family accept.)

Many citizens were shocked at the findings of the local draft boards, during the recent war, at the large number of our young men and women who were rejected because of defects which unfitted them for service. Partly because of this many communities have since been stimulated to an examination of the health facilities and have found them inadequate to meet the need of their people. The result has been an increasing number of requests to the provincial Department of Health for surveys and advice as to the means by which health services could be organized and staffed.

Health units are becoming familiar words in Ontario. Nine units have already been organized in various parts of Ontario, eight of these since 1945. Board members, custodians of their communities' welfare, have seen the need of extending their health activities and, like the elderly gentleman in the county meeting, have shown vision in providing services which include the whole family and its environment. For the program of each health unit is planned to serve all the health needs of its population, both urban and rural, and this is accomplished through the co-operative activities of the medical officer of health, assistant physicians, public health nurses, sanitary inspectors, and clerical staff. Each of these is specially trained to make his contribution to the community program. As sufficient qualified personnel become available the objectives of each unit will one day be realized—a health service through which every member of the community not only will benefit, but will eventually be prepared, through education, to play his part in the prevention of disease and the promotion of healthful living.

What of the cost of a well-conceived health program, developed to meet the needs of the people and in keeping with the best scientific knowledge? The expenditure for such a program stabilizes the investment in education. A child who is well and free from handicaps is enabled to use his educational opportunities to equip

him to be a useful, thinking citizen with the necessary preparation to earn a living and to make a contribution to society. A child, who is frequently absent because of illness or inability to adjust to school, is handicapped, through the loss of educational opportunity, when the time comes for him to earn a livelihood and to take his place as a responsible citizen in his community.

In conclusion, it might be well to consider the present-day trends in health supervision of the child. What are the advantages to him when school health becomes a part of the community program of public health, in which the family is considered when health service is given? The child is known to the health personnel from his birth, so that when he goes to school his health status is known and obtainable. The public health nurse knows many, if not all, of the families in her district; especially is this true of the smaller community or rural area. She has made many contacts in some families, from prenatal care to adult health supervision. In an emergency she may have given bedside nursing care to one of its members — child or adult. It is obvious then that family health service gives the nurse an unusual opportunity to gain the confidence of parents and thus assist them to appreciate the needs of the child, whether it is for dental care, better nutrition, or an understanding of his behavior.

To the parents the family service means a trained person, the district nurse from whom they can seek health guidance. It prevents the confusion which may arise as to the teaching they should follow when, as in specialized services, school, tuberculosis, or infant hygiene, several nurses visit the home within a short period. In certain municipalities in Canada, particularly in the larger urban areas, a separate group of public health nurses, known as visiting nurses, are also responsible for the greater part of bedside nursing. There is an understanding co-operation between these two groups based on a common background of preparation and a mutual interest in the welfare of the family.

The school staff benefits from the close contact with the work of the health department personnel, in terms of an added interest in their own health as well as the child's. It is an opportunity for each teacher to build a background of authentic health knowledge concerning the health conditions and the measures taken to ensure the health and safety of their own community.

The rapid development of health services has increased the responsibilities of all adults who work with and for children. The school teacher has been asked to assume an increasingly large share of health teaching and supervision of the pupils under her care and the response has been magnificent. Together, teachers and nurses are helping to bring to every child the opportunity of health and some measure of equality which may come to them in no other way.

The teacher has an unparalled opportunity to observe her pupils and daily to be on the alert for deviations from what is normal for each child, both his physical condition and his behavior. Her early observations shared with the health personnel will often prevent serious illness for the child and the spread of infection to others in the school. It may also prevent the development of handicaps since early treatment offers the greatest hope of cure.

In the rural areas, especially where the child because of long distances must bring his lunch to school, the teacher can be the first line of defence in the campaign for improving the nutrition of the school child. To the observant teacher the child's lunch box can often account for his lack of energy and progress or his frequent absence from school. A hurried and many times inadequate breakfast, a poor lunch box, and an evening meal lacking in the essentials for good nutrition needed by the child for growth and development may make the difference between success and failure both in school and later life.

A tiny child in a small school, whose teacher said she was dull, was observed during the war years with a lunch of "four cookies." She walked two miles each morning and evening to reach school!

In some areas the school lunch has already been supplemented or a noon meal provided. Teachers and children have been given the willing co-operation of trustees, board members and parents, while the public health personnel and often a nutritionist have acted as consultants to further the project.

Physical health is important, but it is not enough to strive for physical perfection. Without mental and emotional health or stability, it may mean physical strength without judgment; a liability rather than an asset to the individual and those with whom he is associated.

Health personnel everywhere is beginning to realize that mental health is as great a responsibility as the prevention of other conditions and diseases, perhaps greater. And the time to start preventive measures is before the child is born — with the education of his parents. The home, where the child lives and learns, is the first area in prevention to which we must direct our attention. On this preparation will the school have to build.

Perhaps the greatest need of all children today is that we should understand them and their needs as children.

We are all blind until we see that
in the human plan
Nothing is worth the making if it
does not make the man.
Why build these cities glorious if
man unbuilded goes?
In vain we build the world unless
the builder grows.

—EDWIN MARKHAM

A Nurse's Prayer

Lord of this earth, touch every nurse's heart;
Kindle in each, desire to play her part—
To build a world that's patterned to be free,
A world where peace will reign, and liberty.

Give us the women, strong in faith and zeal,
The women who will care, and truly feel
Theirs is a task that they alone can do
Because they have conviction, deep and true.

Give us the nurses, in our day and age,
Whose names will live on future's history-page,
Because a passion for their country's sake
Will make their selfless giving truly great.

Give us women, Lord, who dare to claim
Thee as their Guide, whate'er their rank or fame,
Women whose faith will hold in peace or strife,
To give them courage for their tasks in life.

Give us the nurses who will dare to live
On that new level where they learn to give
Not just their time, but everything of self,
To bring new life to nations, and new health.

Make us the women, Lord, You need this day,
And for Your strength and guidance we would pray.
We pledge our lives to build a better world,
Where flags, for Freedom's sake, will be unfurled.

—EDNA EARLE LEVELTON, R.N.

Fried Foods

As long ago as 1927, scientific research into the digestibility of fried foods revealed that we are wrong in condemning them. In that year, two investigators studied the digestibility of potatoes cooked in various ways. Their conclusions were that the starch of the pan-fried potato is more easily digested than that of the French-fried, and that of the French-fried more easily than that of the boiled variety. When properly cooked, not simply soaked in hot fat, it was found by fluoroscopic observations that the fat actually facilitated the rate of digestion! Within recent time, further studies have been made of the digestibility of other fried foods. The original findings were amply confirmed.

AUX INFIRMIÈRES CANADIENNES-FRANÇAISES

La Lutte Anti-Tuberculeuse

SUZANNE LEBLANC

LA LUTTE ANTI-TUBERCULEUSE a déjà à son actif de consolantes réalisations, grâce à des initiatives privées qui en furent les promoteurs en défrichant le terrain, parfois dans des conditions bien difficiles, en vue de sauver le capital humain qui de jour en jour, au milieu du bouleversement mondial, nous apparaît plus précieux. Rendons hommage au dévouement et aux mérites de ces généreux philanthropes.

Mais nous admettrons facilement qu'il reste beaucoup à accomplir. Dans la seule Province de Québec, il est reconnu que la peste blanche préleve annuellement un tribut d'environ 3,000 vies. En face de cette triste constation, demandons-nous s'il n'y aurait pas lieu de laisser de côté d'autres problèmes, pour donner la primauté à une grande enquête sur les causes de cette terrible hécatombe afin de trouver les moyens d'enrayer le fléau qui fait une telle trouée dans notre génération montante.

Les autorités gouvernementales, ces dernières années, ont largement secondé les premiers travaux philanthropiques, accomplissant de grands et sérieux efforts par des octrois fédéraux et provinciaux, dans le but de lutter efficacement contre ce fléau dévastateur. C'est un devoir social qui doit se faire en collaboration, donc: professionnels, ouvriers, familles —tous doivent coopérer à cette oeuvre fraternelle et de pur patriotisme, convaincus que la prévention est possible et même que la guérison définitive est réalisable.

Au lieu d'user nos énergies à des tentatives éparses, il faut unir nos moyens physiques, intellectuels, et pécuniaires. Il faut adopter une attitude d'ensemble avec un programme bien défini pour prendre notre place dans cette grande armée qui s'emploie à limiter tant de ravages. Notre peuple qui a mobilisé tout son actif humain, qui a dépensé l'argent avec tant de prodigalité pour fins de guerre où tant des nôtres laissèrent leur vie, aura-t-il la sagesse et la prévoyance d'en dépenser pour la survie de ceux qui restent?

Avoir en main dix milles de dollars pour réaliser tout le plan anti-tuberculeux, certes ce ne serait pas suffisant, mais ce serait d'absolue nécessité pour contribuer à cette oeuvre humanitaire et ne pas la laisser s'effondrer tristement.

Cette souscription, comment la partager? Je laisse aux experts ce calcul. Je me contenterai d'y poser quatre grands objectifs: prévention, dépistage, hospitalisation, réhabilitation:

1. *Prévention:* Les phases d'expansion et de déclin de la tuberculose semblent associées d'une manière intime à l'évolution sociale. Elle prend avantage des circonstances défavorables. Il faut, à tout prix, éclairer le peuple, car si le B.K. est la cause déterminante de cette maladie funeste, la cause prédisposante, chez-nous, n'est-elle pas l'ignorance? L'éducation du public doit se faire par la presse, la radio, la distribution de circulaires, de brochures, de tracts,

des conférences dans les écoles, devant les sociétés médicales, et les clubs sociaux, le cinéma, les séances récréatives, etc.

L'éducation, c'est bien, mais il faut plus: Voir à procurer à chacun sa part de soleil, d'air pur, de lumière; lui assurer une alimentation rationnelle, un travail proportionné, un salaire meilleur.

Que de facteurs à considérer et à améliorer! Que de palliatifs à apporter: Multiplier les parcs, terrains de jeux, piscines, camps de santé, cantines scolaires, surtout faire disparaître les taudis malsains, les usines insalubres, etc.

Enfin, comme prévention, la campagne du B.C.G. mérite une mention spéciale. La vaccination, semble-t-il, a la chance de parer aux dangers persistants de contamination. Et la clinique du B.C.G.—souhaitons-lui, non seulement de durer, mais de grandir.

Assurément, la santé publique coûte cher, mais la maladie coûte davantage.

2. *Dépistage:* Pour opérer le dépistage intensif, les ligues, dispensaires, unités sanitaires sont utilisés; la population est invitée à subir périodiquement, et sans frais, un examen médical; les industriels, les patrons de manufacture sont priés de faire examiner leurs employés. Ce moyen est facilité par des cliniques ambulantes dirigées par la ligue anti-tuberculeuse, composées de médecins, de techniciens experts, munies d'appareils fluoro-radiographiques. Le personnel enseignant doit fournir un certificat d'examen pulmonaire, et exiger celui des élèves. Accessoirement, se pratiquent les réactions tuberculiniques.

3. *Hospitalisation:* Voilà un autre objectif très important. Que signifiera un sérieux dépistage, s'il n'y a pas assez d'institutions pour isoler, traiter les malades. Préventorium pour enfants et adultes! Sanatoriums-hôpitaux! Sanatoriums autant de nécessités—construire, outiller, maintenir un personnel compétent. Améliorer les institutions existantes. Encourager les interventions chirurgicales, les recherches de la chimie, dans le seul but d'assurer au patient du confort, des bons soins, une médication curative, un traitement radical. Oh! quelle tâche! Elle ne doit pas être impossible.

4. *Réhabilitation:* Elle doit commencer au sanatorium. Il faut fournir aux tuberculeux tous les moyens de s'instruire, d'apprendre un métier proportionné à leurs forces, afin qu'au sortir du sanatorium, ils puissent se diriger vers un emploi lucratif en relation avec leur état. Aussi, que de nombreuses oeuvres ont été fondées: amicales de malades, associations d'hygiène sociale, oeuvres d'assistances, ateliers de réadaptation. Suggérons aussi, la formation d'un service social dans tous les sanatoriums, d'un service de placement, des assurances sociales, des syndicats corporatifs, etc.

Voilà, en résumé, le plan de la lutte anti-tuberculeuse que notre peuple jeune, fort, intelligent, voudrait voir réaliser pour monter la guerre la plus pressante, celle qui détruira ce fléau social qu'est la tuberculose.

En terminant ce travail qu'il me soit permis de formuler un voeu: Que ces dix milles de dollars soient accordés à la ligue anti-tuberculeuse pour ses activités de 1947.

Note: Les infirmières de la Section de l'Hygiène Publique organisèrent l'automne dernier, un concours parmi les élèves de nos écoles d'infirmières. Le sujet était "Si vous aviez dix milles de dollars pour combattre la tuberculose, comment les employeriez-vous?" Les buts de ce concours étaient les suivants: (1) D'attirer l'attention de toutes les élèves de nos écoles sur la campagne anti-tuberculeuse. (2) De faire réaliser le coût de la maladie même pour le citoyen en santé. (3) De faire de nos élèves, à l'hôpital et plus tard chez les malades, des apôtres de la lutte anti-tuberculeuse.

La coopération n'a pas été celle que nous espérions, mais la qualité des travaux présentés est à souligner et c'est avec plaisir que le jury a accordé les prix suivants:

1er prix: $15, offert par l'Association

Divisionnaire no. 12, mérité par Mlle Suzanne Leblanc, Hôpital du Sacré-Coeur, Cartierville. *2e prix:* $10, offert par la Section d'Hygiène publique de l'A.G.M.E.P.Q., mérité par Mlle Anne-Marie Cayouette, Hôtel-Dieu, Chicoutimi. *3e prix:* $5.00, offert par Mlle A. Girard, directrice de l'Ecole des Infirmières Hygiénistes de l'Université de Montréal, mérité par Révérende Soeur Cécile de Rome, Hôtel-Dieu, Chicoutimi. *4e prix:* Un abonnement au *Canadian Nurse*, offert par Mlle A. Déland, directrice du Service Social à l'Institut Bruchési, mérité par Mlle Augustine Fournier, Hôpital St-Joseph, Rimouski. *5e prix:* Un abonnement au *Canadian Nurse*, offert par Mlle Suzanne Giroux, visiteuse officielle des écoles d'infirmières, mérité par Mlle Yolande Paradis, Hôpital St-Luc, Québec.

Un volume, "L'Infirmière Visiteuse," offert par Mlle A. Martineau, assistante de l'infirmière en chef, Service de Santé, Montréal, à toutes les candidates ayant pris part au concours. Le sort a favorisé Mlle M. A. Rogeau, de l'Hôtel-Dieu, Sherbrooke.

The Provisional Council

The representatives of university schools met for the first time in Montreal on June 20, 1942. Three days later these representatives again met and the Provisional Council of University Schools and Departments of Nursing came into being.

The objectives of the Council were:
(a) To decide upon the form of a permanent association of university schools of nursing.
(b) To determine desirable standards for university schools of nursing represented by members of this Council.
(c) To strengthen the standards of existing university schools of nursing and to support the development of future university schools of nursing where desirable conditions exist.
(d) To strengthen the relationships between university schools of nursing in Canada and other countries.

An annual membership fee of two dollars was agreed upon. Meetings were to be held yearly. Two standing committees of the Council were named: a committee on policy and a committee on studies. Miss K. W. Ellis was elected president, Reverend Mother Allaire, vice-president, and Mary Mathewson, secretary-treasurer. Miss Florence Emory became chairman of the committee on policies. A questionnaire, forwarded to all members of the Council by Miss Emory's committee, revealed a diversity of opinion on all questions asked — the form the organization should take, its financial support, etc.

A further study of standards was proposed in 1944. These were to include:
(a) General standards for university schools of nursing, including organization and administration, qualifications of faculty entrance requirements, student records, etc.
(b) The organization and content of theory and practice in hospital and school of nursing courses, undergraduate and graduate.
(c) The organization and content of theory and practice of public health nursing courses.

Committees were formed to study the graduate and undergraduate nursing courses and the public health nursing courses. The committee on policies was to study general standards for university schools. In March, 1946, the committee studying graduate and undergraduate nursing courses ceased to function. It was replaced by a committee to study all university postgraduate courses in teaching, supervision and administration in hospitals and schools of nursing. Another committee was created to study all basic courses in nursing which had a university connection.

In order to assist members in their thinking prior to the general meeting on July 1, 1946, it was decided to bring to their attention the points on which standards should be laid down — the organization of the school, resources and facilities, and the selection of students. The work of the study committees was temporarily suspended pending a possible reorganization of the Council.

At the general meeting in Toronto on July 1, 1946, the need was expressed for a medium through which those who are teaching in university schools could discuss common problems. It was decided that the group continue under the present plan of a Provisional Council for another two-year period. The objective for this period is to discover the common problems of university schools and departments of nursing. Suggested topics for discussion are to be sent to the secretary by the end of January, 1947. These suggestions will be summarized and forwarded to the members along with the agenda. It was thought desirable to plan for a meeting in May or June, 1947.

The president, Miss K. W. Ellis, and vice-president, Reverend Mother Allaire, were returned by acclamation. Miss H. E. Penhale was elected secretary-treasurer.

For Fillings

Acrylic resin, a material widely used in the United States as a base for false teeth, was developed by the Germans during the war as a permanent filling for direct use in a quickly hardening plastic state in prepared cavities. Fillings inserted in 1943 have been found to be in excellent condition.

Interesting People

Marie Louise Gabrielle Charbonneau, recently appointed as assistant professor and co-ordinator of field experience with the School of Public Health Nursing, University of Montreal, was born in Montreal of French and Scottish parents. She received her preliminary education in the convent of the Soeurs des Saints-Noms de Jésus et de Marie. Graduating from Hotel-Dieu de St. Joseph, Montreal, in 1938, Miss Charbonneau received her diploma in public health nursing the following year from the University of Montreal. She holds the degree of Bachelor of Letters from the same university and has done considerable studying at the Catholic University of America in Washington, D.C.

Miss Charbonneau engaged briefly in private and general staff nursing before she joined the staff of the "Société des Infirmières Visiteuses." She served with the Montreal Health Department for five years prior to her new appointment. She is vice-president of the Association Jeanne-Mance. For relaxation she turns to music and sports—skiing, swimming, and tennis.

Dorothy Maxine Ward, who graduated from the Royal Victoria Hospital, Montreal, in 1941, has been appointed an instructor in the Faculty of Public Health at the University of Western Ontario, London. Miss Ward received the degree of Bachelor of the Science of Nursing from Western Ontario in 1942, majoring in public health nursing. After a year with the Victorian Order of Nurses for Canada at Kitchener, Ont., she engaged in school nursing at Lisgar Collegiate, Ottawa, Ont.

Miss Ward is particularly fond of tennis and skiing. She was one of the leaders in a young people's group which bodes well for her new activity.

Jean MacLean has been appointed supervisor of Red Cross Outpost Hospitals in the Nova Scotia Division of the Canadian Red Cross Society. Miss MacLean is a native of Pictou County, N.S., and received her early education in New Glasgow. She graduated from the Toronto General Hospital from which she received the Mary Agnes Snively Scholarship in 1935 and qualified in the certificate course in teaching and supervision at the University of Toronto. She returned to her home school as head nurse of the fracture and neuro-surgical ward for five years. In 1941 she became supervisor and clinical instructor in general surgery there, leaving in 1943 to join the R.C.A.M.C. During most of the two years that Miss MacLean was in the service she was stationed in Canada. Upon

Garcia, Montreal

GABRIELLE CHARBONNEAU

DOROTHY M. WARD

JEAN MACLEAN

her discharge, she enrolled for the course in administration in schools of nursing at the McGill School for Graduate Nurses receiving her Bachelor of Nursing degree in 1946.

Marion Crawford Story has been appointed provincial director of the Junior Red Cross for Saskatchewan. Born in England, Miss Story was educated in Edmonton, graduating in 1928 from the University of Alberta Hospital. After a brief flurry of general staff nursing in Edmonton and in California, she joined the school nursing staff in Edmonton where she worked from 1930 until her enlistment in the R.C.A.M.C. in 1942. During a year's leave of absence in 1935, Miss Story received her training in public health nursing at the University of Toronto.

Miss Story's war service in the internment camp in Medicine Hat preceded going to England and Belgium, with a brief interlude on the hospital ship, *Lady Nelson*. On her discharge, she returned to the University of Toronto for advanced work in public health nursing.

Through the years Miss Story has always participated in various association activities. She was chairman of the public health section of the Edmonton Branch of the A.A.R.N., treasurer and corresponding secretary of the University of Alberta Hospital Alumnae Association, a member of the University of Toronto School of Nursing Alumnae Association, and of the Nursing Sisters' Association. She is also a member of the Regina Business and Professional Women's Club. Reading and handiwork fill her leisure moments.

MARION C. STORY

The new chairman of the national Committee on Private Duty Nursing, replacing the old General Nursing Section, is **Barbara Key** of Hamilton, Ont. Miss Key is well fitted by her experience to give excellent leadership to this group of nurses. After graduating from the Hamilton General Hospital, she engaged in private duty for many years. Miss Key has been keenly interested in the development of community nursing registries throughout Ontario. Through her chairmanship of the Board of Directors of the Hamilton Registry, she has had an excellent opportunity to study the most effective methods of operating such registries.

Miss Key had a great deal to do with the demonstration course in practical nursing as

BARBARA KEY

ADA SANDELL

sponsored by the Hamilton Community Nursing Registry under the egis of the R.N.A.O. She was responsible for the details of arrangements and saw the course through to its successful conclusion. Miss Key is also a member of the Health Division Committee of the Council of Social Agencies. Her brief leisure periods give her opportunities for reading and knitting—when she can find the wool! She is also an enthusiastic photographer.

Ada Sandell is preparing to return to the mission field in Korea where she labored for so many years before the war. Born in England, Miss Sandell spent her early years in Magog, P.Q. In 1922, she graduated from Lamont (Alta.) Public Hospital and, after various preparatory courses, was appointed to a United Church mission in West China. Unrest and civil strife deterred her departure for two years during which she engaged in social service work in Copper Cliff, Ont. When she finally reached China in 1926 the upheaval in the inland areas was such that she was transferred to Hamheung, Korea.

Miss Sandell organized the nursing profession in northern Korea, establishing the first school of nursing in that part of the country. Until war interrupted her activities in 1940, her work progressed. During the war years, Miss Sandell served as superintendent of nurses at the Lamont Public Hospital.

When she returns to Korea, Miss Sandell will not be able to go back to her former school as that part of the country is under Russian occupation. Her present task will be to assist with the organization of a nursing department at Ewha University in Seoul. Our good wishes go with her. May her work prosper!

MARGARET G. KENNEDY

Margaret Glen Kennedy has undertaken an interesting piece of work at the Queen Elizabeth Hospital, Toronto, which is devoted to the care of chronic invalids. Miss Kennedy will be educational director and will have charge of a broad program for the entire nursing staff—graduates and assistants. She will demonstrate the value of this type of hospital in the general health program of the community, correlating the work of the nurses in the hospital to the total picture.

Miss Kennedy graduated in 1936 from the Toronto General Hospital. She engaged in private duty nursing until her enlistment with the R.C.A.M.C. in 1940. She saw service in England and Italy. On her discharge she joined the Victorian Order of Nurses, completing her public health nursing course at the University of Toronto last year.

Preview

Should nutrition be included as an important part of our public health programs? Off hand, most of us would give a simple answer, "Yes, of course." How many of us are well informed on the actual nutritional status of our citizens? Do we know what advice should be given? The first of a series of articles on nutrition, prepared by members of faculty of the University of Toronto, will give us some of the answers next month. **Dr. E. W. McHenry,** head of the Department of Nutrition, will start the series off for us.

Notes from National Office

World Health Organization

THE FOLLOWING INFORMATION is summarized from the November, 1946, Bulletin of the International Council of Nurses:

The necessity for co-operation with the World Health Organization and the United Nations Educational, Scientific and Cultural Organization was stressed. Miss Schwarzenberg has had interviews with Dr. A. Stampar, chairman, and Dr. G. B. Chisholm, secretary general of the World Health Organization and an application for the most desirable form of co-operation has been made.

The twenty-two functions of the World Health Organization give us a clear idea of its objectives as outlined by Elmira B. Wickenden, adviser member of the U.S. delegates to the International Health Organization:

1. To act as the directing and co-ordinating authority on international health work.

2. To establish and maintain effective collaboration with the United Nations, specialized agencies, governmental health administration, professional groups and such other organizations as may be deemed appropriate.

3. To assist governments, upon request, in strengthening health services.

4. To furnish appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of governments.

5. To provide, or assist in providing, upon the request of the United Nations, health services.

6. To establish and maintain such administrative and technical services as may be required, including epidemiological and statistical services.

7. To stimulate and advance work to eradicate epidemic, endemic and other diseases.

8. To promote, in co-operation with other specialized agencies where necessary, the prevention of accidental injuries.

9. To promote, in co-operation with other specialized agencies where necessary, the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene.

10. To promote co-operation among scientific and professional groups which contribute to the advancement of health.

11. To propose conventions, agreements and regulations, and make recommendations with respect to international health matters and to perform such duties as may be assigned thereby to the Organization and are consistent with its objectives.

12. To promote maternal and child health and welfare and to foster the ability to live harmoniously in a changing total environment.

13. To foster activities in the field of mental health, especially those affecting the harmony of human relations.

14. To promote and conduct research in the field of health.

15. To promote improved standards of teaching and training in health, medical, and related professions.

16. To study and report on, in co-operation with other specialized agencies where necessary, administrative and social techniques affecting public health and medical care from preventive and curative points of view, including hospital service and social security.

17. To provide information, counsel, and assistance in the field of health.

18. To assist in developing an informed public opinion among all peoples on matters relating to health.

19. To establish and revise as necessary international nomenclatures of diseases, of causes of death, and of public health practice.

20. To standardize diagnostic procedure as necessary.

21. To develop, establish, and promote international standards with respect to food,

biological, pharmaceutical, and similar products.

22. Generally to conduct all necessary action to attain the objective of the organization.

Visit to Hospitals in Great Britain

The following information, concerning the visit of the general secretary, Canadian Nurses' Association, to Great Britain, was contained in a report as presented to the Executive Committee, December 5-7, 1946:

Britain, like every other country, is in a state of confusion in so far as nursing is concerned. Nurses are in short supply, hospital beds are filled to overflowing, and health services are expanding everywhere. If and when the new Health Service Bill is implemented the nursing service needs will be increased beyond any possibility of meeting these needs.

The Ministry of Health, driven to desperation, has taken the matter in hand in a most practical manner and has set up a committee to analyze the nursing problems with a view to making recommendations which will remedy the situation as quickly as possible. Unfortunately, however, at the time we interviewed the Chief Medical Officer of the Ministry of Health we were informed that the committee making the study will produce a confidential report and although we were given a great deal of information we were requested to treat this as strictly confidential.

The Ministry of Health set up a steering committee to initiate a study of the nursing situation. This committee consists of the following: Sir Robert Wood, Minister of Education, who is chairman of the Committee, with representatives from the Ministry of Health, Ministry of Pensions, Ministry of Labor, and the Board of Control Committee; (the latter corresponds to the Department within our Government responsible for the administration and hospitalization of the mentally ill).

The actual study is being conducted by a small committee known as the working party, consisting of two nurses, experienced and able women, a medical doctor, and the director of the working party, Dr. Cohen, who is an economist and psychologist. The working party has been busily engaged in carrying out the work connected with the investigations, analyzing these, and preparing the reports for the steering committee.

The first step in the study consisted in:

1. *An examination of all previous reports on the nursing situation:* (a) Lancet Commission; (b) interdepartmental report; (c) Horder and Rushcliffe reports; (d) report on social medicine; (e) reorganization of nursing by G. V. Carter.

2. *Job Analysis:* (a) Investigation of the student nurse wastage; (b) investigation of recruitment program for student and assistant nurses and the structure of the nursing profession; (c) pre-nursing education; (d) methods of training; (e) organization of personnel in hospitals and other institutions; (f) comparative programs in other countries.

Conferences were held with Dr. Cohen and his assistant. Dr. Cohen has initiated the testing program for student nurses and is also conducting the investigation on the nurse wastage which incidentally amounts to the alarming figure of an annual 60 per cent wastage for student nurses in the hospitals in Great Britain. The wastage of students in Canada for 1944 was 1,200 or 12 per cent.

The study covers the period 1937-45 and includes a report of the students enrolled for each year. The breakdown of the numbers leaving during the first year is along these lines: (a) number who leave before entering wards; (b) number who leave after entering wards; (c) number who leave in second and third year and subsequently and the total.

Causes of wastage include: sickness, marriage, failure in examinations, discharge by hospital, resigned and reasons for resignation, other causes.

Interviews have been held with as many students as possible who for the above reasons cancelled training and much valuable information has thus been obtained.

A psychologist is making the job analysis, in co-operation with an experienced nurse who interprets the nursing situation, on quite an extensive scale. The analysis includes: (a) the duties of nurses; (b) length of time spent on duties (comparative weight is given to each duty); (c) functions involved in carrying out duties; an endeavor is made to relate functions to phases of training in the existing syllabus, and to relate these to the aptitude of the nurse.

The psychologist endeavored to assess the qualities of personality necessary at a minimum level for successful training and an analysis of qualities in individual fields in relation to other fields of nursing.

Hospitals selected for the job analysis study were representative of general or special fields of nursing. Procedure consisted of: conference with matrons of hospitals from whom general information regarding the hospital and its organization was obtained. Each special ward representative of that field of nursing was visited and conferences held with sisters in charge of wards, to whom the program was explained and information sought.

The sister outlined in detail the duties of each worker on the ward; students were observed as they performed special duties and thus the psychologist obtained a general understanding of the extent of the scientific knowledge necessary and the skill required by the student to perform these duties.

It was interesting to find the psychologist had taken into consideration the physical facilities of each hospital ward and was quick to discover the discrepancies in the physical lay-out of the ward due to faulty planning, etc.

It was especially interesting to find she had made a diagram of each ward showing the relationship of the utility rooms (called sluice rooms in Great Britain) to the ward itself. The psychologist was very critical of the hazards arising from the physical factors which in turn played such an important part in the nursing service and actual nursing care of the patients.

The report of the working party is to be ready for submission to the Ministry of Health by December 31, 1946. What will happen from there on will be awaited with keen interest.

Preparation of the Assistant Nurse:

Mrs. Bennett, chief nursing officer of the Ministry of Labor, arranged for and accompanied me on my visit to Chelmsford and St. Margaret Hospitals at Epping in Essex County. Chelmsford Hospital operates for the care of the chronically ill. Assistant nurses are assigned to this hospital following their preliminary training at the Pre-training Centre.

At Epping the student is enrolled as an assistant nurse and spends one month. During this period she receives some theoretical instruction and is taught the following nursing procedures: ward management, bed-making, bed baths, general care of the patient, taking temperature, pulse, respiration, etc. I observed a class being taught at Epping where an experienced sister tutor was in charge. The teaching was being given very slowly and on a very elementary level. The class consisted of twelve students, the majority from Ireland, all radiating abundant health, and all with varying backgrounds of education and experience.

A committee, composed of matrons, interviews the applicants for training as assistant nurses. If they find an applicant with more than average educational preparation and having the necessary qualifications for general training, she is advised to enter a school of nursing offering general training. They are also informed that having successfully completed the second year assistant nurse training, they may, if they so desire, enter general training. A time allowance is made for previous training and this training is also considered in lieu of complete high school.

There are not sufficient numbers of applicants for the assistant nurse courses. The reasons given were as follows: According to the Rushcliffe salary schedule, the salaries of assis-

tant nurses and domestic workers are almost equal. During training the assistant nurse receives £55 or $220 the first year and £65 or $260 the second year. If assigned to a tuberculosis sanatorium, they receive £65 the first year and £75 the second year. Following training they receive £95 which is increased by £5 bi-annually until they reach a maximum of £160. It requires a period of twenty-two years before this salary level is attained. The attitude of the professional nurse group is definitely one of superiority and the assistant group are naturally somewhat resentful.

From my observation of the quality and extent of the teaching program and experience being given the assistant nurse, also from discussion of the course with experienced sister tutors and matrons, I am of the opinion that the course being given the assistant nurse in Great Britain is very similar to the practical nurse course being given in Canada in a nine-month to one year period.

General training for the State Registered Nurse:

Visits to the London, St. Thomas, Westminster, and Kings College Hospital, and to the Sector hospitals connected therewith, were arranged on my behalf by Dame Katherine Watt, British Ministry of Health.

Miss M. G. Lawson, deputy chief nursing officer, accompanied me on some of the above visits. My visit to the London hospital consisted of observing classroom and ward teaching. A full day was spent observing what is called a Study Day.

The London hospital introduced a new study day scheme of training in August, 1945, designed to ensure that the student nurses were spared the strain of theoretical training and practical ward work at one and the same time. The study day is spent in attendance at doctors' lectures followed by nursing classes.

The student nurse has an eleven-week period in the preliminary training school followed by three periods spaced at intervals during her three years' training in which she has a weekly study day. These study day periods are spread over the three years of training and each student nurse has a total of fifty-three study days during this time. This total is made up of three sixteen-day periods in the first, second, and third years respectively, and one four-day period before the final State examinations, with one day on entry to the hospital to introduce her to it.

The preliminary training school of eleven weeks allows for 202 hours of theoretical and practical instruction in nursing and the basic sciences, 31 hours for physical training, 50 hours for housewifery and gardening, and 88 hours for private study.

There are four preliminary school terms in the year held from January to March, April to June, July to September, and October to December. The number of students admitted to each term is from 40 to 45.

Each student receives a total of 351 hours of classroom lectures and demonstrations, including practice demonstrations over a three-year period. Compared to the Proposed Curriculum for nurses in Canada or the American Curriculum Guide, this seems very limited indeed. It must, however, be remembered that, in addition, a great deal of *ward* teaching is actually given on the wards by the sister in charge. For the most part these sisters were more experienced than the majority of head nurses and supervisors in Canadian schools of nursing. I observed on many of the wards, during the early morning hours when patients were receiving morning care, and the quality of nursing care being given compared very favorably with that observed in many Canadian and American hospitals.

From these observations and from conferences with matrons, sister tutors, and sisters in charge of wards, my impressions are as follows:

Voluntary hospitals in Britain conducting schools of nursing have not endeavored to increase the theoretical content of the curriculum as we have in this country. They are of the opinion, and we cannot deny there is basis for this opinion, that student

nurses who are required to give so much nursing service to hospitals cannot possibly obtain maximum benefit from a greatly increased theoretical program.

On the other hand several British matrons who were associated with American and Canadian nurses, both in the army and with UNRRA, stated that the nurses from this continent seemed very well prepared for public health nursing. Special reference was made to the nurses who had trained in collegiate schools of nursing and who had demonstrated real ability to organize and carry out an excellent program of public health nursing.

Due to the limited time at my disposal it was unfortunately necessary to cancel several appointments and further visits of observation which had been planned by Dame Katherine Watt. The experience obtained from even four short weeks (each day filled to overflowing) has already proved profitable and will, I feel sure, justify in the future the time so spent.

Executive Committee Meeting

A meeting of the Executive Committee, Canadian Nurses' Association, was held in Calgary on December 5-7, 1946. Those present included the officers, the chairmen of standing committees and the presidents of all provincial registered nurses' associations except Prince Edward Island. The various reports will be summarized for the March issue of *The Canadian Nurse*.

Resolutions arising from the meeting are as follows:

1. WHEREAS the nursing profession over a period of years has attempted through legislation to develop a standard of nursing education and service to meet the ever-increasing health needs of the country, by higher educational entrance requirements and continuous improvement of clinical teaching facilities;

AND WHEREAS in view of the present shortage of nursing service, certain interested groups have suggested that the number of nurses might be increased by lowering the entrance standards and by re-opening schools of nursing in hospitals which previously were considered inadequate as practice fields;

AND WHEREAS it has been shown that in the years 1940-45, with a general rise in the educational requirements, the number of students in the approved training schools of the country increased by 45 per cent;

AND WHEREAS the present approved schools can accommodate more students:

Be it resolved, That the Executive Committee of the Canadian Nurses' Association go on record as being strongly opposed to the lowering of educational requirements for entrance to schools of nursing, and to the opening of schools in hospitals without proper teaching and clinical facilities.

2. *Resolved*, That the power to administer the affairs of the association as laid down in this by-law shall not involve any change of policy on the part of the sub-committee or include power to incur any extraordinary expenditure. Copies of the minutes of the meetings of the sub-committee shall be sent to all members of the Executive Committee within a period of two weeks from the date of each meeting. The proceedings of each meeting of the sub-committee shall be ratified at the next meeting of the Executive Committee.

3. *Resolved*, That the British Nurses' Relief Fund be continued, and that the provincial associations, the Nursing Sisters' Association, and any other interested groups be notified of the existing needs; also that the provincial associations notify National Office within two weeks if they can make a contribution toward bringing a European nurse to the International Council of Nurses Congress.

4. WHEREAS there has been widespread discussion of the new tax regulations for married women and

WHEREAS it is anticipated that a certain number of married nurses will give up nursing when the regulations come into effect, in part due to the resentment expressed by their husbands, whose income tax will be altered:

Be it resolved, That the Executive Committee of the Canadian Nurses' Association communicate by telegram with the Minister of Finance urging that the application of the new regulation be deferred for one year because of the serious shortage of nursing service at the present time.

5. *Be it resolved*, That the Canadian Nurses' Association write the Canadian Red Cross Society expressing our thanks for the gift just given to establish a demonstration Nursing School.

Notes du Secrétariat de l'A. I. C.

L'Organisme International de Santé

Les renseignements suivants sont le résumé d'un article paru dans le Bulletin du Conseil International des Infirmières en novembre 1946:

La nécessité pour le Conseil International des Infirmières de coopérer avec l'Organisme International de Santé de même qu'avec l'organisme d'éducation, de science, et de culture des Nations Unis fut demontrée lors de la dernière réunion du Conseil. Mlle Schwarzenberg a rencontré les docteurs A. Stamper et G. B. Chisholm, respectivement président et secrétaire de l'Organisme International de Santé et une demande leur fut adressée pour déterminer de quelle façon nous pourrions le mieux coopérer.

Les vingt-deux fonctions de l'O.I. de S. nous donnent une bonne idée des buts que se propose cet organisme. Mme E. Wickenden, conseillère des E.U. et déléguée de son pays à l'O.I. de S., nous donne ces fonctions:

1. D'agir comme autorité directrice et coordinatrice dans le travail international de santé.

2. D'établir et de maintenir une collaboration efficace entre les Nations Unies, les associations spécialisées, les Ministères de la Santé, les groupes professionnels et autres corps, si on le juge à propos.

3. D'aider les gouvernements sur demande à renforcer les services de santé.

4. A fournir l'assistance technique appropriée, en cas d'urgence, l'aide nécessaire sur demande ou acceptation des gouvernements.

5. De munir de service de santé ou aider à le faire les Nations Unis qui en feront la demande.

6. D'établir et maintenir des services administratifs et techniques nécessaires tel que service d'épidémologie et de statistiques.

7. De stimuler et faire progresser les travaux qui ont pour but de faire disparaître les maladies épidémiques et endémiques et toutes autres maladies.

8. De promouvoir, en coopération avec d'autres associations au besoin, la prévention des accidents.

9. De promouvoir, en coopération avec d'autres organismes spécialisés si nécessaire, l'amélioration de la nutrition, de l'habitation, de la salubrité publique, de la récréation, des conditions économiques et de travail et de tous les autres facteurs ayant une répercussion sur la santé.

10. De promouvoir la coopération entre les groupes professionnels et scientifiques qui travaillent aux progrès de la santé.

11. De proposer des conventions, des ententes et des règlements, de faire des recommendations concernant les questions internationales de santé et accomplir les devoirs que l'O.I. de S. peut-être appeler à remplir et qui sont de son ressort.

12. De promouvoir le bien-être et la santé des mères et des enfants et de développer l'habilité à s'adapter harmonieusement dans un milieu nouveau.

13. De développer des activités dans le domaine de l'hygiène mentale, spécialement celles qui concernent les relations humaines.

14. De promouvoir et diriger des recherches concernant la santé.

15. De promouvoir et d'améliorer les normes de l'enseignement théorique et pratique de la santé chez les médecins et chez les autres professions connexes.

16. D'étudier et faire rapport, en coopération avec d'autres groupes si nécessaire, des techniques administratives et sociales ayant une répercussion sur la santé publique et aussi sur les soins donnés aux malades, tant au point de vue curatif que préventif, les services hospitaliers et de protection sociale.

17. De donner des renseignements, des directives et de l'aide dans les questions de santé.

18. D'aider à former chez le public une opinion bien éclairée sur toutes les questions de santé.

19. D'établir et reviser, aussi souvent que nécessaire, une nomenclature internationale des maladies, des causes de décès, et des règles d'hygiène publique.

20. D'uniformiser les moyens de diagnostique, au besoin.

21. De développer, d'établir, et de promouvoir les normes internationales concernant les comestibles, les produits biologiques, pharmaceutiques et autres produits semblables.

22. En général de faire tout ce qui est nécessaire pour atteindre le but de l'organisme.

Visite de la Secrétaire-générale de l'A.I.C. aux Hôpitaux de Grande-Bretagne

La Grande-Bretagne, comme dans bien d'autres pays, il y a de la confusion dans le monde des infirmières. Il y a pénurie d'infirmières, les hôpitaux débordent de patients, les services de santé se développent partout. Lorsque la nouvelle loi du service de santé sera appliquée, le besoin d'infirmières sera si grand qu'il sera impossible de répondre à la demande.

Le Ministre de la Santé désespéré a pris la chose en main et en homme pratique a formé un comité qui a pour fonction d'analyser les problèmes du nursing et de faire des recommendations pour remédier à la situation aussitôt que possible. Malheureusement, lorsque nous avons rencontré l'officier médical en chef du Ministère de la Santé, l'on nous informa que le rapport présenté par le comité chargé de cette étude serait confidentiel, tout de même bien des renseignements nous furent donnés que l'on nous pria de garder secrets.

Le Ministère de la Santé organisa un comité de direction pour commencer l'étude de la situation du nursing en Grande-Bretagne. Les personnes suivantes formèrent ce comité: Sir Robert Wood, Ministre de l'Instruction Publique, qui est le président de ce comité, des représentants du Ministère de la Santé, des Pensions, du Travail, et de la Commission du Contrôle (cette dernière est chargée de l'hospitalisation des aliénés et de la régie de leurs biens).

L'étude est présentement faite par un petit comité nommé bureau du travail et est composé de deux infirmières femmes capables et d'expérience, d'un médecin et d'un directeur, le docteur Cohen, qui est à la fois un économiste et un psychologiste. Le bureau du travail a été très actif à faire des enquêtes, à analyser ces dernières afin de faire un rapport au comité de direction. Voici comment l'on procéda dans cette étude:

1. En examinant tous les rapports précédamment faits sur le nursing tel que: (a) Lancet Commission; (b) interdepartmental report; (c) Horder et Rushcliffe; (d) rapport sur la médecine sociale; (e) réorganisation du nursing par G. V. Carter.

2. Par l'analyse: (a) De cause de départs des étudiantes infirmières; (b) programme de recrutement des infirmières et des aides; organisation de la profession; (c) instruction à l'admission à l'école d'infirmières; (d) méthodes de formation professionnelle; (e) organisation du personnel dans les hôpitaux et les institutions; (f) comparaison des programmes des divers pays.

Le docteur Cohen a commencé un programme d'épreuves en orientation professionnelle pour les étudiantes et il fait aussi une enquête sur les causes des départs des étudiantes infirmières. Cette perte d'étudiantes est alarmante: elle est annuellement de 60 pour cent dans les hôpitaux de Grande-Bretagne. (Au Canada la perte de candidates, le nombre de candidates quittant annuellement nos écoles, était en 1944 de 1,200 soit 12 pour cent.)

Cette étude s'étend de l'année 1937-45 et comprend l'étude d'un rapport fait sur chacune des étudiantes inscrites dans les écoles chaque année. Ces rapports sont classifiés dans l'ordre suivant: (a) Nombre d'élèves quittant l'école avant d'aller auprès des malades; (b) celles qui quittent après avoir été dans les salles; (c) celles qui quittent durant la seconde et troisième année de leur cours ou encore quittent l'hôpital après leur graduation et le chiffre total pour chaque hôpital.

Les causes de départs sont la maladie, le mariage, échecs des examens, renvoi par l'hôpital, démission et raison de la démission, et causes diverses. Il y a eu autant que possible d'entrevues avec les étudiantes qui ont quitté leur cours pour l'une des raisons déjà citées et des renseignements très importants ont été obtenus.

Un psychologiste fait un travail d'analyse étendu aidé d'une infirmière expérimentée qui lui interprête la situation. L'analyse comprend: (a) Le travail de l'infirmière; (b) la

durée de temps passé à l'accomplissement des travaux (durée définie pour chaque tâche); (c) chacune des actions faites pour accomplir un travail. Une tentative est faite pour voir si les travaux accomplis sont en rapport de l'enseignement reçu à date par l'infirmière et aussi pour juger si ces travaux correspondent aux aptitudes que l'on juge nécessaire à une infirmière.

Le psychologiste tente d'établir les qualités nécessaires de la personnalité pour suivre avec succès un cours d'infirmière. Il tentera ensuite d'analyser ces qualités dans divers milieux relativement aux milieux hospitaliers. Les hôpitaux choisis pour cette analyse représentent aussi bien les hôpitaux généraux que spécialisés. Voici comment l'on a procédé: Entretien avec la directrice de l'hôpital qui donne les informations générales concernant l'hôpital et son organisation. Chaque salle d'un service différent est visitée dans un entretien avec l'hospitalière de la salle, le programme de l'étude lui est expliqué, et on lui demande des renseignements. L'hospitalière décrit en détail les devoirs de chaque personne de la salle. L'on observe les étudiantes faisant leur travail. Le psychologiste comprend les connaisances scientifiques requises et l'habilité nécessaire pour accomplir ce travail déterminé.

Il est intéressant de noter que le psychologiste a remarqué les facilités matérielles de travail de chaque hôpital et il ne faut pas long à se rendre compte des causes qui contrairement rendent le travail difficile. L'une de ces causes est souvent la mauvaise disposition des salles, fautes qui n'ont pas été corrigées sur les plans. Le psychologiste lors de ses visites fit un plan de chaque salle, sa disposition en rapport de chaque salle d'utilité. Le psychologiste a critiqué vivement d'une part les risques qui découlent de la mauvaise disposition des salles et d'autre part leur répercussion sur le travail du personnel hospitalier et sur les soins à donner aux malades.

Le rapport du bureau du travail doit être prêt pour présentation au Ministère de la Santé le 31 décembre 1946. Ce qui doit arriver après celà est attendu avec beaucoup d'intérêt.

Préparation des Aides: Madame Bennett, officier en chef du Nursing au Ministère du Travail, avait organiser une visite à l'Hôpital de Chelmsford et à l'Hôpital Ste-Marguerite d'Epping dans le comté d'Essex. A Chelmsford, l'hôpital est pour les malades chroniques, les aides sont envoyées à cet hôpital après leur cours préliminaire au centre d'entraînement. A Epping, l'aide est reçue comme assistante de l'infirmière et passe un mois à cet hôpital. Durant ce temps elle reçoit un enseignement théorique et elle apprend aussi comment administrer une salle, à faire les lits, à donner un bain au lit, les soins du malade au lit, à prendre la température, le pouls et la respiration. J'ai assisté à un de ces cours donné par une institutrice, infirmière d'expérience, l'enseignement, très élémentaire, se faisait lentement et d'une façon simple. Il y avait douze élèves par classe, la plupart venaient d'Irlande étaient rayonnantes de santé. Elles venaient de milieux très différents et leur dégré d'instruction variait grandement.

Un comité, formé de directrices, reçoit la jeune fille qui désire suivre un cours d'aide. Si l'on constate que l'aspirante a une instruction au-dessus de la moyenne et a les qualités requises pour une infirmière, on lui conseille d'entrer dans une école d'infirmière. On lui dit aussi qu'après deux ans d'étude comme aide elle peut-être admise dans une école d'infirmière. Si la candidate a déjà une partie de ses études comme infirmière, l'on en tient compte lors de son entraînement et cette expérience peut aussi remplacée les études primaires jugées insuffisantes.

Il n'y a pas suffisamment de candidates pour ces cours d'aides. Cet état de chose s'explique par les raisons suivantes:

Selon l'échelle de salaire Rushcliffe, les salaires des aides et des domestiques sont à peu près les mêmes. Durant leurs cours les aides reçoivent £55 ou $220 la première année et £65 ou $260 la deuxième année. Si elles sont envoyées dans un sanatorium de tuberculeux, elles reçoivent £65 la première année et £75 la deuxième année. Leur entraînement terminé, elles reçoivent £95 avec augmentation de £5 tous les deux ans jusqu'à un maximum de £160. Il faut travailler vingt-deux ans pour obtenir ce maximum de salaire. L'attitude du groupe professionnel qui est définitivement une attitude de supériorité vis-à-vis le groupe des aides est aussi une cause de réssentiment.

Après avoir observé la qualité et la durée de l'enseignement du programme et des expériences faites à date dans l'entraînement de l'aide et aussi d'après les discussions que j'ai eu avec les directrices et les institutrices, je suis de l'opinion que le cours qui est présentement donnée en Grande-Bretagne est à peu près le même que celui qui est donné

aux aides (practical nurse) au Canada durant une période de neuf à douze mois.

Formation de l'Infirmière Enregistrée: Des visites furent faites aux hôpitaux suivants: The London, St. Thomas, Westminster, et Kings College Hospital et les hôpitaux satellites qu'ils administrent, grâce à la courtoisie de Dame Katherine Watt, Ministre de la Santé, qui fit les démarchés nécessaires.

Mlle Lawson, déléguée de l'officier en charge du nursing au Ministère de la Santé, m'accompagna lors de quelques unes de ces visites. A ma visite au London, j'ai observé l'enseignement fait en classe et l'enseignement clinique. J'ai passé une journée entière à observé ce qui est appelé "une journée d'étude." Cette journée d'étude fut introduite dans le cours par le London Hospital en août 1945 dans le but d'épargner à l'élève une trop grande fatigue résultant de l'enseignement qu'elles reçoivent qui est à la fois théorique et pratique dans les salles de malades. La journée d'étude consiste à assister à des conférences données par des médecins et qui sont suivies de classe sur le nursing.

Durant onze semaines, l'élève reçoit des cours à l'école préliminaire. Ces cours sont suivis de trois périodes d'étude, espacés à différents intervalles, durant les trois années du cours. Durant ces périodes d'étude, l'élève a chaque semaine sa journée d'étude. Durant ces trois années de cours, l'élève a chaque semaine sa journée d'étude. Durant ces trois années de cours, l'élève assiste à cinquante-trois journées d'étude, soit seize journées chaque année plus quatre jours avant les examens d'enregistrement et une journée à l'entrée pour visiter l'hôpital.

La période préliminaire de onze semaines d'étude comprend 202 heures d'enseignement théorique et pratique en science et nursing, plus trente-une heures de culture physique, cinquante heures d'enseignement ménager et jardinage, et quatre-vingt-huit heures d'étude privée.

Il y a quatre cours préliminaires de donnée chaque année, de janvier à mars, avril à juin, juillet à septembre, et octobre à décembre. Le nombre des élèves varie entre quarante à quarante-cinq. Chaque élève, durant son cours, reçoit 351 heures d'enseignement théorique et de démonstration. Si l'on compare ce programme d'étude au programme proposé aux écoles d'infirmières du Canada ou a celui des Etats-Unis, celà semble très peu. Mais l'on doit se rappeler qu'en plus de celà un nombre considérable d'heures d'enseignement clinique est actuellement donné dans les salles par l'hospitalière. La majorité de ces hospitalières et surveillantes ont plus d'expérience que les infirmières occupant les mêmes charges dans nos hôpitaux du Canada. Je suis allée dans plusieures salles le matin à l'heure des traitements et la qualité des soins donné peut se comparer avec avantage avec ceux que j'ai observé dans plusieurs hôpitaux canadiens et américains.

A la suite de ces observations, de conférences avec les directrices, les institutrices, et les hospitalières voici mes impressions: Les hôpitaux volontaires (ne recevant aucun subsides de l'Etat) en Grande-Bretagne s'efforcent d'ajouter au programme plus d'étude théorique comme nous l'avons fait dans notre pays. Toute fois, l'opinion est (je crois que nous ne pouvons nier le bien fondé de cette opinion) qu'il est impossible pour des élèves qui ont un grand nombre d'heures de service à faire à l'hôpital de bénéficier d'un programme d'étude théorique plus considérable.

Si d'une part j'ai fait ces observations sur les infirmières de Grande-Bretagne d'autre part plusieures directrices anglaises (matrons), qui travaillèrent soit dans l'armée soit dans UNRRA avec des infirmières canadiennes et américaines, firent les observations suivantes: Que nos infirmières semblent très bien préparées pour l'hygiène publique. L'on a remarqué particulièrement celles qui firent leur cours dans "Collegiate Schools" (cours qui aux E.U. correspond à notre cours universitaire de cinq ans); elles démontrèrent une habilité remarquable pour organiser et rendre à bonne fin un programme d'hygiène publique.

Le temps que j'avais à ma disposition étant limité j'ai du renoncer à faire plusieurs visites.

Malgré celà, l'expérience acquise durant les quatre semaines que j'ai passé à observer (chaque jour était très chargée) m'est déjà utile et j'en suis certaine l'avenir prouvera que ce fut du temps bien employé.

Safety Hint

Keep all medicines and cleaning substances in secure containers, out of reach of young children, plainly marked as to content, and preferably in locked cabinets.

Ward Hypodermic Tray

CATHERINE H. CRAWFORD

THE CENTRAL SUPPLY ROOM at the Royal Victoria Hospital, Montreal, has developed an arrangement for supplying sterile equipment for the giving of hypodermics which, while not unique, has proven very satisfactory. There is a marked saving of time and equipment—both precious commodities in a busy hospital.

The hypodermic set-up includes the following:

1. A sterile hypodermic set, consisting of a medicine glass in which are: one 2 cc. syringe, plunger and barrel separate, one No. 25, 5/8" needle, and two gauze sponges. These have been done up in a double cotton cover and autoclaved.

2. A ward hypodermic tray containing hypodermic sets; a bottle of sterile water, plain glass of 100 ml. capacity, fitted with a rubber stopper covering the lip; a bottle of denatured alcohol; a glass holding sterile tissue forceps in alcohol; a jar of sterile sponges; a file for opening ampules; an alcohol lamp with spoon for use if boiling water is necessary to dissolve the drug, e.g., pantopon tablet; matches; an enamel dish.

The wards' responsibilities may be outlined as follows:

1. Each ward comes for a supply of sterile sets in a special basket every morning. This may be exchanged for a fresh supply at any time. Unless there are very heavy demands, replenishment is seldom necessary until late afternoon or evening. Slackness on one ward covers the extra demand from another ward.

2. The sets are kept in a wooden basket on the ward. The basket has a central partition running lengthwise. Sterile sets are kept on one side, unsterile on the other, both sides being labelled to prevent any error. The ward is responsible for: (a) keeping the count to twelve sets; (b) returning the basket to the central supply room when all sets have been used; (c) returning breakages for replacement.

3. The bottle of sterile water is changed each day.

The central supply room is responsible for the maintenance of the equipment. Their procedures are as follows:

Tray and opened syringe package

Syringe basket showing partition

1. The hypodermic sets are dismantled. The syringes are checked for mismated parts; breakages are replaced.
2. Glassware is washed in hot soapy water, rinsed in plain hot water.
3. Needles are cleaned with water and ether. They are checked for barbs and damaged needles are sharpened in the hospital instrument department.
4. The separate parts of the syringe, barrel and plunger are each wrapped in a single sponge. The needle is also embedded in a sponge. These pieces are packed into the medicine glass, wrapped and loosely packed in large wire-mesh baskets for autoclaving.

The central supply room sends the equipment to be sterilized. Hypodermic sets are autoclaved twice daily, more often if necessary, loosely packed in wire baskets. No solution can be autoclaved in a bottle with a fitted stopper as the pressure will blow the stopper out. To overcome this difficulty, the bottle is filled with tap water and the fitted rubber stopper is loosely held in place by a cloth cap covering the complete neck of the bottle. After they have been sterilized and before they are issued, the cloth cap is removed and the rubber stopper is inserted into the bottle neck and fitted over the lip without contamination.

Obituaries

Mary Isabel Howes, a graduate of the Toronto General Hospital, died recently in Walkerton, Ont., in her eighty-first year.

Kathleen M. Knight, a graduate of the Montreal General Hospital, died recently in Vancouver in her fifty-ninth year. Miss Knight served with the Laval Unit of the C.A.M.C. during World War I. She was invalided home after three years' service and spent the two following years in recuperation. For some time she had charge of the x-ray department at M.G.H. Later she engaged in social service work in Montreal and Vancouver until ill health compelled her to retire in 1944. Miss Knight had a bright, kindly, sympathetic nature and was beloved by her many friends.

Mary Pearl Lumby, who graduated from the Sarnia General Hospital, died recently in Bowmanville, Ont. Following post-graduate study at the University of Western Ontario and in the United States, Miss Lumby served on the staffs of several hospitals. She was superintendent of the Cochrane hospital for seven years, transferring to Bowmanville in 1941. In 1943 she accepted the post of superintendent of the Niagara Falls General Hospital, returning two years later to Bowmanville. Her devotion to her work and her friendly personality won her many friends wherever she went.

Margaret Florence McKeown, a graduate of Grace Hospital, Toronto, died recently in Toronto. For twenty-six years she had served as welfare nurse with the Canadian Pacific Express Co.

Jean Grant (Brodie) Murray, who was born in Tarlair, Scotland, and graduated from the Royal Infirmary, Dundee, in 1910, died suddenly on November 27, 1946, in Toronto. Mrs. Murray had been industrial nurse with the *Maclean Hunter News Weekly* since 1930.

Nellie Maud (Gadsby) Parnall, oldest living graduate of the Mack Training School for Nurses, St. Catharines, Ont., died recently at the age of seventy-six. Last spring, Mrs. Parnall was honored at a dinner on the occasion of the fiftieth anniversary of her graduation. She had been president of her alumnae association for many years and was one of the organizers of the graduate nurses' association.

Doris Selley, a graduate of Wellesley Hospital, Toronto, died recently from injuries received in a motor accident.

Reverend Sister Mary Martha, for over twenty-five years on the staff of the Pembroke General Hospital, died on December 2, 1946. Prior to going to Pembroke she had served at the Ottawa General Hospital.

Enid Wilkins, who graduated from the Portage la Prairie Hospital in 1944, died recently from injuries received in a fall. Miss Wilkins had nursed in Portage, Winnipeg, and Deer Lodge before going as company nurse to Island Falls, Man., last June.

STUDENT NURSES PAGE

Tetanus

JACQUELINE THOMSON

Student Nurse

The General and Marine Hospital, Owen Sound, Ontario.

MR. W, A WELL-BUILT MAN, twenty-five years of age, was admitted on a medical ward of our hospital. This was his first admission to hospital, and his first major illness. He was born in Canada, of Irish parents, and had lived on a farm at some distance from our city most of his life. He had become the sole support of his family which included a crippled father, his mother, and a deaf brother. Though facing difficult circumstances, the family was highly esteemed in the community and Mr. W was regarded as a serious young man who worked hard and long to pay bills promptly and to care for his family.

On the day of his admission to hospital Mr. W had gone to work in his fields as usual. During the morning he had developed a stiff neck and lower jaw. This complaint became increasingly severe and by noon he was unable to sit upright on the seat of his machine. He stopped work, walked with difficulty to his car, and drove to the nearest village to seek medical aid. Dr. M, after a brief examination, decided that his patient was a very sick young man and brought him to the hospital for immediate treatment. He made a tentative diagnosis of tetanus or "lockjaw."

Although of swarthy complexion our patient's color was now dusky and mottled, his brows were elevated and wrinkled, and the corners of his mouth were drawn upwards in a peculiar grin. This facial expression, known as "risus sardonicus," caused by contraction of the muscle fibres, particularly those of the masseter muscles of the jaw, is a common manifestation of tetanus. Respirations were rapid and shallow, and the pulse rate accelerated. The temperature, taken by rectum, was 102.4 degrees.

After preliminary sensitivity tests. Mr. W was given 15,000 units of tetanus antitoxin by Dr. M immediately on his admission to hospital. This serum is prepared from the blood of horses which have been immunized against the toxins of tetanus bacilli. Because of the foreign proteins contained in it, some patients suffer from anaphylaxis, or serum-sickness, when tetanus antitoxin is administered. Fortunately, Mr. W did not show sensitivity to the serum. To confirm his diagnosis, Dr. M performed a lumbar puncture, and spinal fluid was sent to the laboratory for determinative tests. Reports disclosed that the number of white blood cells per cubic millimeter of fluid was elevated above normal. Globulin was slightly increased. Cultures did not produce any pathological organisms. These findings substantiated the physician's diagnosis. To supply fluid to the feverish and perspiring patient, iso-

tonic saline solution was administered intravenously, 1000 cc. every four hours. Into the saline, 5,000 units of tetanus antitoxin was injected. To further combat the infecting organism, 50,000 units of penicillin was given intramuscularly, followed by 30,000 units every three hours. Paraldehyde, drams IV, was administered by rectum, as considered necessary, to induce sleep and lessen muscular activity. By the same channel, sodium amytal, grains VI, given every eight hours, held the muscular paroxysms in check.

During the evening, Mr. W's condition became more serious. His temperature soared to 104° and his pulse became rapid, weak, and thready. The abdomen was rigidly retracted, and the skeletal muscles contracted until the arched body rested on the heels and head only, in the manifestation known as opisthotonos. Respirations were labored, and frothy fluid oozed from between his tightly clenched teeth. Perspiration was profuse. Since delirium was present, severe muscular paroxysms occurred as the patient tossed restlessly.

Constant nursing care was necessary and, because of the restlessness, the physician performed a "cut-down" on the patient's ankle to administer parenteral fluids and the combative medication. Tepid sponging, using long gentle strokes to avoid inducing muscular spasms, reduced the fever slightly during the night. By means of a small catheter attached to a suction-machine, phlegm and mucus were removed from the patient's throat. During the early morning, the bladder became distended and catheterization was necessary.

During the second and third day of his illness, Mr. W showed a very slight improvement although his temperature reached 105.6° and hovered at that point for several days following. Sodium luminal was now substituted for the sodium amytal as sedation, five grains being given by mouth every eight hours. Fifty thousand units of tetanus antitoxin was administered intramuscularly every twenty-four hours, in addition to the 20,000 units which was now being given with the intravenous fluid every six hours. A severe convulsion occurred on the fourth day and was brought under control, after forty-five minutes of violent twitching, by use of sodium pentothal which is ordinarily used as an anesthetic.

During the next few days, glucose and saline administrations were given continuously by intravenous channels. Soap-suds enemata were given daily to cleanse the lower bowel. On the seventh day there was a definite improvement. Mr. W responded and although he was not well oriented at first, he reacted quite normally by evening. Coughing became a troublesome symptom but the patient, holding himself rigid to prevent muscle-spasm, was able to expectorate copious amounts of frothy, purulent phlegm. A duodenal tube was carefully inserted and a specially vitaminized formula was given every four hours to provide nourishment. This was utilized without any distress and on the following day the formula was given every two hours. Sedation was discontinued gradually, but the intravenous fluid was continued until the tenth day, by which time the patient was markedly improved. All rigidity had disappeared and the temperature was only slightly elevated in the afternoon. The antitoxin and penicillin were now gradually discontinued.

Although considered a debatable point by some authorities, Mr. W was cared for during the first ten days as a strictly isolated patient. He could give no history of a skin wound when initially examined and had no abrasions or skin lesions. The site of invasion by the tetanus bacillus remained unknown but, since Mr. W pursued farming as an occupation, the possibility of having ingested the deadly spores existed. Although he was in good physical condition generally, Mr. W's mouth and teeth were in extremely bad condition. Dental caries had almost completely destroyed the molars, and the incisors were broken and decayed. The gums were red and spongy and bled readily

while oral hygiene was being carried out. Constant nursing attention was necessary, day and night, and it was deemed advisable to guard against any possibility of cross-infection by the institution of careful isolation technique by the three nurses assigned to the case. Equipment used in the patient's room was carefully wrapped and autoclaved for one hour so that both spores and vegetative forms of the bacilli would be destroyed.

Watchful, gentle bedside nursing was of the utmost importance during the first two weeks of Mr. W's illness. The room was kept darkened, warm, well-ventilated and free from drafts. At night, lamps were carefully shaded. Noise was controlled in the adjacent rooms and corridor. Mindful of the extreme hyperesthesia present in such cases, and that the slightest touch, jar, or noise might precipitate tonic spasm, accompanied by excruciating pain, nursing care was carried out as gently as possible. Bed-clothing of light weight was used and supported by body cradles. During convulsions mild restraint was exercised so that the patient might not injure himself. A wooden tongue depressor, padded with bandage, prevented tongue damage at such times as were necessary. The back, heels, and elbows were rubbed gently with alcohol and cocoa butter to aid circulation and improve skin tone. Small, soft pillows of various sizes supported and protected the body. Mouth care was difficult to carry out because of the rigidity of the jaws. Cotton-tipped applicators soaked in peroxide were used to cleanse the teeth and gums, and a mixture of glycerin and lemon juice aided in cleansing the tongue and preventing the formation of crusts and sordes. Close observation of the condition of the patient's pulse, respiration, color, and skin was necessary so that any reaction from the large doses of antitoxin and penicillin would be noted immediately. Fluid intake and output were likewise carefully measured so that edema or urinary suppression might be guarded against. Valuable nursing experience was gained through preparing for, and assisting, the physician with lumbar puncture and venepuncture, as well as in maintaining a continuous flow of parenteral fluid. The constant intramuscular injections gave rise to many painful sites and the patient was made more comfortable by gentle massage over these areas. By varying the site of injection each time, a small measure of pain was prevented.

Mr. W's recovery was hastened by his willingness in carrying out any advice which would speed his discharge from hospital. He was anxious to resume the delayed spring work on his farm and, by inquiring of the friends who called, we were able to tell our patient that kindly neighbors had rallied and were helping out during his absence. This information greatly relieved Mr. W's mind, and during his convalescence he appeared to quite enjoy the rest and nourishing food. Although naturally somewhat shy and reserved, he was interested in hearing about the nature of his illness. Being a farmer he knew that "lockjaw" often appeared among cattle and horses but had neither seen the disease among his own livestock, nor in the section in which he lived. We were able to tell him that the tetanus bacillus is normally found in the intestinal tract of herbivorous animals and is transmitted to the soil by means of their excreta. Here, faced with an unfavorable environment, the bacillus forms spores and is able to survive for many years without oxygen. Because of this phenomenon, hay, grass, straw, and soil may prove to be the origin of a case of tetanus. It was evident that Mr. W would be able to do some local health teaching on his discharge from hospital by relaying to other farmers the information that the practice of chewing hay or straw could be exceedingly dangerous, and also that abrasions, especially puncture wounds, which were contaminated by soil or animal excreta, could result in "lockjaw." He was much impressed when he learned that a small dose of tetanus antitoxin, administered early, provides reliable prophylaxis against the disease. Attention was drawn to

Mr. W's teeth and he was urged to see a dentist as soon as possible even though removal of all his teeth would likely be suggested. The importance of good oral hygiene was pointed out and we felt quite sure that Mr. W would act upon the advice he had received.

When discharged from hospital, three weeks from the date of his admission, Mr. W seemed to bear no evidence of his serious illness. He had regained his lost weight, his color was healthy and, except for his decayed teeth, he was considered to be in excellent physical condition when examined by his physician. He remained shy and reticent throughout his convalescence and, although his expressions of gratitude on his discharge were tendered with rather youthful awkwardness, we knew that our patient was sincerely appreciative. We, as nurses, felt amply rewarded since, for all of us, it was a new experience. This had been the first established case of tetanus to be admitted to our hospital in some time, and we were deeply grateful to Dr. M for his patience in answering our numerous questions. Because of our lack of experience with this disease we had depended upon his instruction and guidance throughout the case.

Book Reviews

Effective Living, by C. E. Turner, A.M., Ed.M., Sc.D. and Elizabeth McHose, B.S., M.A. 432 pages. Published by The C. V. Mosby Co., St. Louis. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 2nd Ed. 1945. Illustrated. Price $2.50.

Designed to meet the needs of students in high school classes for a reliable text in their courses in health or hygiene, the subject matter of this book is on a sufficiently high level to make it useful as the text for courses in this topic given to the preliminary students in our schools of nursing. With probationers coming into the school from widely distributed centres, it is inevitable that there should be a marked difference in the basic health instruction each has received during her schooling. Some will have had a sound introduction to the whole field of personal and community health. Others have only the most sketchy information on many of the topics. Since student nurses have such limitless opportunities for health teaching, both by personal example and by actual conversation, it is essential that they should early receive a thorough grounding in factual information. This text would fill that purpose admirably.

The authors have divided their material into three parts: effective living for the individual, in the family, and in the community. Each part is subdivided into units, fifteen in all. Several of these latter are broken down still further. Where limited time is a factor, the instructor could combine or eliminate such units as seemed advisable.

The text is well illustrated both by photographs and line drawings. Each unit closes with a series of problems and activities designed to stimulate further interest in the students.

Body Mechanics in Nursing Arts, by Bernice Fash, B.P.E., B.S. 130 pages. Published by McGraw-Hill Book Co. Inc., 330 West 42nd St., New York City 18. 1946. Illustrated. Price (in U.S.A.) $2.75.

Reviewed by Winnifred MacLean, Assistant Superintendent of Nurses, Royal Victoria Hospital, Montreal.

All who have to do with the process of developing the student into a skilled and efficient nurse will study this book with interest and enjoyment. The illustrations are excellent.

The first section is devoted to tests, well illustrated, which prove the principles underlying good body mechanics. These principles are listed with examples of nursing procedures in which they may be applied. For instance, Experiment No. 2 deals with the flexors and abductors of the arms:

"*Principles:* (1) Keep the parts of the body as close to the vertical axis of the body as possible. (2) Stand close. (3) Use the largest,

strongest muscle groups and the greatest number of muscles.

"Examples:

1. Bed bath: Have the patient at the near side of the bed to prevent reaching.

2. Bedmaking: When mitering linen, loosening bed linen, and tucking, stand as close to the bed as possible so that the arms may remain close to the body. When folding linen hold it so that it may be brought as close to the vertical axis of the body as possible.

3. Tray carrying: When carrying a tray by grasping along the top edge, holding it with the thumbs up, the strain is placed on two small muscles: the flexors and extensors carpi radialis. When carrying it by holding it on the palms, the load is divided among more muscles. The strain is placed on the flexors profundus sublimis digitorum and palmaris, in addition to the two small muscles, the flexors carpi radialis and ulnaris; thus there is less load on each muscle because more muscles are put to work."

The student is asked to list in her notebook other examples to which the principles are applicable. One can readily realize how the nurse's energy and time can be conserved and muscle strain lessened. All of this will benefit the patient by increasing her comfort and peace of mind, because the nurse knows how to move her skilfully, almost effortlessly, i.e., getting the helpless patient into a wheel chair.

Lastly, the nurse's posture will be improved. She will have learned to carry herself with head up, shoulders back and body erect. For, even in the simple procedure of taking a pulse, she has learned, "Frequent distortions result from holding the watch too low and too close to the body, so that stooping is required in order for the second hand to be within range of vision."

Medical Services by Government, by Bernhard J. Stern, Ph.D. 208 pages. Published by The Commonwealth Fund, 41 East 57th St., New York City 22. 1946. Price (in U.S.A.) $1.50.

Reviewed by Dorothy Tate, Director, Public Health Nursing, Provincial Board of Health, British Columbia.

Bernhard J. Stern, Ph.D., through his concise account, traces the responsibilities assumed by local, state, and federal governments. In including the scope, trends, and nature of medical services provided by governments, he presents information which will influence future developments. The changing emphasis of medical services, demonstrated by specific experiences, further impresses one with government's increased acceptance of its role in providing medical services, directly or indirectly.

Dr. Stern's description of historic and contemporary activities provides a stimulus to our thinking of the future position of government in medical services. It is a source of information from which an evaluation may be made for the future program of adequate medical care for the people. The subject material is of vital importance and is presented in a logical and interesting manner.

Medical Education and the Changing Order, by Raymond B. Allen, M.D., Ph.D. 142 pages. Published by The Commonwealth Fund, 41 East 57th St., New York City 22. 1946. Price (in U.S.A.) $1.50.

Reviewed by Hazel Keeler, Director of Nursing Education, University of Manitoba.

In this monograph, the author reviews the present educational preparation of medical doctors in the light of the adjustment aim of education. Dr. Allen points out the weaknesses in present-day medical training and suggests ways and means of overcoming these inadequacies. He says that in order to produce successful doctors it is necessary first to attract, by wise counselling, into the medical schools the above-average and gifted students from the secondary schools. Within the medical school Dr. Allen advocates a broadening of the curriculum to include the social sciences and the humanities. He emphasizes that it takes a man, not a machine, to understand a man.

He urges that every effort be made to provide opportunity within the various courses for the student to learn the scientific method of thinking and how to apply the experimental method in the testing of hypotheses of his own devising.

Much of what Dr. Allen says about the inadequacies of present-day medical training applies just as well to the preparation of other professional workers and to the preparation of nurses in particular. Anyone interested in the preparation of the professional worker will find this monograph interesting and stimulating.

Appointments - Transfers - Resignations

Alberta

The following are recent staff changes in the Division of Public Health Nursing, Alberta Department of Public Health:

Appointments: *Elizabeth R. Lea*, formerly of Peers district, to Edmonton Well Baby Clinic; *Marguerite Keays*, ex-nursing sister from New Brunswick, to Lomond; *Mrs. Margaret Faulkner*, after an absence from the staff of three and a half years, to Newbrook.

Resignations: *Rosemarie Leier* from Newbrook to go to St. Paul's Hospital, Saskatoon.

British Columbia

The following is information concerning the staff of the British Columbia Public Health Nursing Service, Provincial Board of Health:

Appointments: *Pauline Yaholnitsky* (Canora General Hospital, Sask., and University of British Columbia public health course; McGill University administration and supervision course) as supervisor, public health nursing, in the Cariboo, Prince Rupert, and Peace River district; *Dorothy Gerrard* (St. Paul's Hospital and University of B.C.) and *Dorothy Holmberg* (Royal Jubilee Hospital, Victoria, and University of B.C.) to Abbotsford-Matsqui-Sumas; *Margaret Whillans* (Saskatoon City Hospital and University of B.C. public health course), *E. Layton* (Royal Alexandra Hospital, Edmonton, and University of Toronto public health course), and *Beth Laycraft* (Lamont Public Hospital and University of Alberta public health course) to Chilliwack; *Doris Barish* (Grey Nuns' Hospital, Regina, and University of B.C. public health course) to Coquitlam; *Mrs. Frances Lloyd-Young* (Royal Jubilee Hospital, Victoria, and University of B.C. public health course), and *Kathleen Hart* (St. Paul's Hospital, Vancouver), while awaiting admission to university for a public health course, to Courtenay; *Hazel Provins* (St. Paul's Hospital and University of B.C. public health course) to Maple Ridge; *Audrey Ades* (B.A. and B.A.Sc., University of B.C. and Vancouver General Hospital) to Kamloops; *Dorothy Paulin* (B.A.Sc., University of B.C. and Vancouver General Hospital), *Lorraine Carruthers* (Royal Jubilee Hospital, Victoria, and University of B.C. public health course), and *Dorothy Morris* (Vancouver General Hospital and University of B.C. public health course, with B.A. and B.A.Sc. degree in nursing) to Saanich; *Nancy Lee* (Vancouver General Hospital and University of B.C. public health course) to Nelson; *Marjorie Leach* (Memorial Hospital, St. Thomas, Ont.), and *Margaret Lattimer* (Royal Columbian Hospital, New Westminster, and University of B.C. public health course) to Peace River; *Mrs. Doris Brentzen* (Royal Columbian Hospital and University of B.C.), and *Mrs. Gene Kennedy* (Vancouver General Hospital and B.A.Sc., University of B.C.) to Prince George; *Miriam Cressman* (Vancouver General Hospital) to Prince Rupert; *Dorothy Neuman* (Vancouver General Hospital and University of B.C. public health course) to Revelstoke; *Helen McQuay* (Kingston General Hospital and University of Toronto public health course) to Vernon; *Ellen Urvold* (St. Paul's Hospital, Vancouver, and University of B.C. public health course) to Langley; *Mrs. Kathryn (Simmons) Ramsay* (Vancouver General Hospital) to Keremeos; *Lucille Giovando* (B.A.Sc., University of B.C. and Vancouver General Hospital) to Cumberland; *Margaret Abernethy* (B.A.Sc., University of B.C. and Vancouver General Hospital) to Cranbrook; *Frances Hobden* (B.A. and B.A.Sc., University of B.C. and Vancouver General Hospital) to Surrey; *Mary Greenfield* (Regina General Hospital and University of B.C. public health course), *Mrs. Margaret Greig* (Royal Jubilee Hospital and University of B.C.), *Phyllis Dangerfield* (Royal Columbian Hospital and University of B.C. public health course), and *Shirley Main* (B.A.Sc., University of B.C. and Vancouver General Hospital) to Central Vancouver Island health unit; *Joan Morrison* (B.A.Sc., University of B.C. and Vancouver General Hospital) to Duncan; *Yvonne Nedelec* (St. Eugene's Hospital, Cranbrook, and University of B.C. public health course), and *Joyce Driver* (B.A.Sc., University of B.C. and Vancouver General Hospital) to Alberni; *Margaret Darling* (St. John's General Hospital and University of Toronto public health course) to Ladysmith; *Gwen Oxley* (Royal Columbian

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Hospital and University of B.C. public health course) to Okanagan Valley health unit; *Jean Taylor* (B.A.Sc., University of B.C. and Vancouver General Hospital) to Kelowna; *Irene Butler* (B.A.Sc., University of B.C. and Vancouver General Hospital) to Enderby; *Elizabeth Beattie* (Guelph General Hospital and University of Toronto public health course) to Armstrong; *Dorothy Irwin* (Victoria Hospital, London, and B.Sc.N., University of Western Ontario) to Nanaimo.

Resignations: *Mrs. Margaret Little* from Ladysmith; *Mrs. Joanne Brewster* from Surrey and is living in Vancouver; *Mrs. Eileen Jones* from North Okanagan Valley health unit to return to Alberta; *Amy Smith*, *Betty Plumer*, and *Evelyn Tier* to study at the University of B.C.; *Eileen Snowden* from Langley to be married; *Mrs. Alma McRae* from Cranbrook; *Olive Garrood* from Kamloops and, after a trip to Australia, will retire to West Vancouver; *Dorothy McTier* from Alberni; *Margaret Beveridge* from Saanich to be married; *Charlotte Sellsted* from Maple Ridge to be married; *Florence Graham* from Coquitlam to be married; *Dorothy Udall* from Prince George to be married; *Eden Wayles* from Cowichan health committee to be married; *Margaret Mathews* from Revelstoke to enter Department of Nursing, University of B.C.; *Betty Pickard* from Central Vancouver Island health unit to enter the University of B.C.; *Margaret Goble* from Courtenay to do public health work in Ontario.

Isabelle Lyons (St. Paul's Hospital and University of B.C. public health course) is employed as an exchange public health nurse with the Metropolitan Health Committee, Vancouver. *Margaret Cammaert* (B.Sc. (Nursing), University of Alberta) has joined the Metropolitan staff and is working in Summerland. The services of *Ruby Tinkiss*, who is nursing specialist in infant and prenatal care with the Division of Maternal and Child Hygiene, Department of National Health and Welfare, have been made available in the generalized public health field for three months and she will be stationed in Penticton. *Mary Maclean*, formerly of Nanaimo, is now in Chilliwack. *Freda Hilton*, who has been in Creston, is now in Haney. *Betty Elliot*, formerly of Duncan, is organizing public health nursing service in Port Coquitlam. *Janet Pallister*, formerly of Keremeos, is organizing a generalized public health nursing service in Oliver which had previously been served by the V.O.N. *Eileen Ramsay*, who

FROM A CLINICAL POINT OF VIEW - - - - -

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resigned from Langley, is now with the Quesnel district. *Margaret Campbell*, who has been in Abbotsford, is now in Kamloops. *Gladys Skinner* has left Peace River and is now in Cumberland. *K. Comerford* has been transferred to Creston. *Marion Boyd*, of Summerland, is now with the Division of Venereal Disease Control as an epidemiological worker. *Muriel McConnell*, of Langford, is with the Child Guidance Clinic. *Helen Etherington* has received a scholarship to take advance work in public health at the University of Toronto.

CITY OF VICTORIA HEALTH DEPARTMENT

B. Miller and *Mrs. E. Louis* are recent appointments and resignations include *M. Frank* and *Mrs. B. Flury*.

Ontario

The following are appointments to the Ontario Public Health Nursing Service:

Margaret Hallawell (Toronto General Hospital and University of Toronto certificate course), formerly with the Toronto Department of Public Health, as public health nurse with the newly-organized school health service for the Township of Vaughan and the Villages of Richmond Hill and Woodbridge; *Elaine Crosscombe* (Toronto General Hospital and University of Toronto certificate course) to Kingston Board of Health; *Mrs. Hilda Roy* (Hamilton General Hospital and University of Western Ontario certificate course), formerly with Peel County health unit, to Brant County health unit; *Helen Larkin* (New York Hospital and University of Toronto certificate course), who has been serving with the Parry Sound Board of Health, to Oshawa Board of Health.

Saskatchewan

Mrs. Helen Best (Universities of British Columbia and Toronto) has been assigned to do part-time work in the Eatonia district where her husband is minister of the United Church. *R. I. Garvie* (Universities of Saskatchewan and Toronto) is working in the Outlook district. *N. Madden*, *L. P. Irwin*, and *A. M. Eklund*, returned nursing sisters, are new appointments and are serving at Humbolt, Wolseley, and Swift Current respectively. *J. L. Gorchinsky* and *M. E. McCann* (University of Saskatchewan) have been assigned to Yorkton and Regina districts.

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Mrs. M. Mlazgar and *Mrs. D. Jardine* are new members of the Weyburn region staff. Other appointments include: *A. Hyer*, Assiniboia; *E. J. Thorburn*, Melfort; *S. Thompson*, Regina; *L. Wright*, Meadow Lake; *M. Edy*, Moose Jaw; *E. Campbell, J. Cloarec*, Swift Current.

Edna Moore, who has worked in the Canora district for some time, has recently transferred to Health Region No. 3, Weyburn, and has been replaced by *R. Korchinski*. *I. V. Scriver*, who has been in charge of the nursing home at Cumberland House for the past four years, has transferred to the Department of Social Welfare. She will be in charge of the Children's Home at Green Lake.

G. E. Matheson, V. Johnson, and *R. Cornelius* resigned to be married.

M.L.I.C. Nursing Service

The following is information concerning staff changes in the Nursing Service of the Metropolitan Life Insurance Company:

Transfers: *Simonne Rouillard* (Hôpital St-Luc, Montreal, and University of Montreal public health course) from Montreal to St. Jean, P.Q.; *Anna Theriault* (Sacred Heart Hospital, Cartierville, P.Q. and University of Montreal public health course) from St. Jean to Drummondville, P.Q.

Resignations: *Françoise Gauthier* (St. Charles Hospital, St. Hyacinthe and University of Montreal public health course) from Montreal; *Adeste Martin* (Hotel Dieu Hospital, Montreal, and University of Montreal public health course) from Drummondville.

Victorian Order of Nurses

The following are recent appointments to, transfers, and resignations from the various branches of the Victorian Order of Nurses for Canada:

Appointments: *Mrs. Bernice Redmon* (Saint Philip Hospital Medical College of Virginia and Medical College of Virginia public health course) and *Phyllis Jones* (University of Toronto School of Nursing) to Toronto; *Nellie Beaton* (City of Sydney Hospital) as nurse-in-charge at Canso; *Normina McLean*, formerly nurse-in-charge at Gananoque, to Edmonton.

Transfers: *Carol Sellhorn* from Edmonton to nurse-in-charge at Prince Albert; *Joan Stock* from Ottawa to nurse-in-charge at Ste. Anne de Bellevue; *Helene Rousseau* from Ottawa to nurse-in-charge at Pointe Claire;

Helen Rush from Galt to nurse-in-charge at Fort William; *Marianne Coleman* from staff nurse to nurse-in-charge at Galt; *Catherine Ross* from Prince Albert to open new branch at Medicine Hat; *Jacqueline Blanchard* from Ste. Anne de Bellevue to Montreal; *Viola Youmans* from Vancouver to Ottawa.

Resignations: *Bessie Jackson* from Fort William to take up other work; *Jeanne (Sterne) MacKay* from Brantford; *Mrs. Mary Hargrave* from Montreal; *Rita (Coady) McIsaac* from Montreal to take up other work; *Lois Skinner* from Toronto to be married; *Patricia Merriman*, leave of absence, from Montreal; *Florence Rand* from Canso following her marriage; *Margaret Campbell* and *Mrs. Billie Grainger* from York Township.

First Industrial Nurse

An attempt is being made to identify the industry in which a nurse was first employed in Canada and to obtain all relevant particulars available about this company and the nurse.

Present information indicates that the first full-time industrial nurse was employed in this country in 1909. Any other information of prior date which can be verified might be submitted to the Division of Industrial Hygiene, Ontario Department of Health, Parliament Bldgs., Toronto 2.

News Notes

BRITISH COLUMBIA

GREATER VANCOUVER DISTRICT:

The semi-annual meeting of the Greater Vancouver District, R.N.A.B.C., was held at St. Paul's Hospital, with Janie Jamieson presiding. The program was in charge of Mrs. M. Mitchell, president, North Vancouver Chapter. A gratifying increase in the attendance at the meeting and an active participation in discussion reflect a growing interest in nursing affairs. A recommendation from the executive, that the various groups contact their members with a view to widening the means of disseminating important information on a co-operative basis, was well received.

The Vancouver Chapter has enjoyed a series of interesting programs, one of the most outstanding being the address given by Lyle Creelman, who worked with UNRRA. She showed pictures of England and the camps for

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THE VICTORIAN ORDER OF NURSES FOR CANADA

Has vacancies for supervisory and staff nurses in various parts of Canada.

Applications will be welcomed from Registered Nurses with post-graduate preparation in public health nursing and with or without experience.

Registered Nurses without preparation will be considered for temporary employment.

Apply to:

Miss Elizabeth Smellie

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114 Wellington Street

Ottawa.

Displaced Persons in Great Britain and the occupied zones in Germany. Parcels are still being sent to British and Dutch nurses by all chapters. The North Vancouver Chapter reports the adoption of a convalescent home for British nurses on the Isle of Wight. This is a special project, the expenses being met by voluntary contributions by the members. The Vancouver Chapter also reports that scholarships are being offered to chapter members who make application.

Miss Charters, chairman of the district Public Health Section, gave an account of the institute on mental hygiene which was held for the benefit of the members of the public health sections of the local chapters.

Official representatives of the various nursing associations presented a "March Past" of their aims and activities. In attendance were: Miss Chestnut, president, Students' Council, V.G.H.; Miss Copeland, Students' Council, St. Paul's Hospital; Mmes Mitchell and L. Grundy, presidents, North Vancouver and Vancouver Chapters; Miss Williams for Mrs. Beach, president, West Vancouver Chapter; Evelyn Mallory, president, R.N.A.B.C.; Alice Wright, executive secretary, R.N.A.B.C.; E. Braund, director, provincial placement service; D. Jamieson, vice-president, V.G.H. alumnae; Beth McGillivary, St. Paul's Hospital alumnae; F. Rowell, Winnipeg General Hospital alumnae; Mrs. Mercer, president, Science Girls Club; K. Panton, Nursing Sisters' Association.

The guest speaker was Dr. Harvey Agnew, secretary, Canadian Hospital Council, and editor of *The Canadian Hospital*. His theme was "Nursing: its past and present in relation to the changing patterns and the current needs and education."

An appropriate background for the program was the history of nursing project prepared by the September class of probationers. This consisted of a display of dolls dressed in copies of various nursing costumes from Sairy Gamp's time to the present.

MANITOBA

BRANDON:

At a meeting of the Brandon Graduate Nurses Association, Marion Patterson gave a report of the 25th annual meeting of the Manitoba Hospital Association held in Winnipeg. At a later meeting, with Nan Crighton presiding, $25 was voted to the purchase of books for the children's section of the public library. Laura Fair, executive secretary, M.A.R.N., was guest speaker and her talk on "Old and New Legislation for the Nursing Profession" proved very interesting. She also described many of her experiences while serving overseas. The social hour was under the direction of Mrs. H. Alexander's group.

The association held a reception at the home of Marjorie Trotter for Jean Petty, who was home on leave from her duties with UNRRA in Germany. Mrs. E. Hannad presided at the tea table, assisted by Mrs.

M. A. McKenzie, B. Brigham, A. Bennett, M. Patterson, I. Lamont, and B. Taylor.

NEW BRUNSWICK

SAINT JOHN:

General Hospital:

At a recent meeting of Saint John General Hospital Alumnae Association, the president, Miss Hartley, was in the chair. A gift of $25 was donated towards the Library Fund of the student body of the school of nursing. Florence Lamb gave an interesting talk and demonstration on "Handicrafts."

Alice Newcomb is now operating-room supervisor. Mrs. John Stevens is residing in Snow Lake, Manitoba, and is in charge of the first aid hospital there.

St. Joseph's Hospital:

The friends of Elsie O'Leary, of New York City, were pleased to see her when she was here on a month's vacation.

ST. STEPHEN:

At a recent meeting of St. Stephen Chapter, N.B.A.R.N., a lengthy discussion followed the reading of the resolution passed at the C.N.A. biennial meeting relative to the academic requirements for admission to schools of nursing. The treasurer gratefully acknowledged the receipt of $100 from the medical staff of Chipman Memorial Hospital to help to defray expenses of the N.B.A.R.N. annual meeting. It was decided to discontinue sending parcels to a Dutch nurse and enquire regarding relief now needed by British nurses, with a view to helping them. A committee was appointed to interview local merchants regarding possibilities of obtaining white stockings for nurses.

ONTARIO

DISTRICT 6

The annual meeting of Chapter B, District 6, R.N.A.O., was held at Port Hope Hospital, when the following officers were elected to serve during the coming months:

President, Ena Swan; vice-president, M. Scott; secretary-treasurer, Florence Campbell; committees: nominating, C. E. Droppo, M. H. Kellough, M. Polson; membership, A. Dufton, E. Porter, I. Ramsey; section chairmen: hospital and school of nursing, J. Graham; general nursing, Mrs. I. Cowin; public health, G. Aylsworth; representatives to: press, Mrs. M. E. Smither; *The Canadian Nurse*, A. Minifie.

To cover the expenses incurred by the chapter in sending food parcels to nurses in England, a marathon bridge was held.

QUEBEC

MONTREAL:

Children's Memorial Hospital:

Activities of the staff since last summer included their annual Hallowe'en party, proceeds of which were donated to the fund

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REGISTERED NURSES' ASSOC'N. OF BRITISH COLUMBIA

Placement Service

Information regarding positions for Registered Nurses in the Province of British Columbia may be obtained by writing to:

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MENTHOLATUM

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for sending nurses to the biennial meeting of the C.N.A.; a group of handicraft classes given by Mrs. J. D. Miller, head of the occupational therapy department; and a talk by Miss Reardon on the various cardex systems used throughout hospitals in Montreal. A number of parcels have been sent to the nurses in the Netherlands.

The hospital has started a new affiliation with the Brightlook Hospital, St. Johnsbury, Vt., bringing the number of affiliating hospitals up to twenty-two.

Post-graduate students recently completing their courses were: Rev. Sisters Helen Gouin and Eugenia Bachand; Misses Phyllis MacEachern, Alice Hoefer, who has accepted a position with the Shriners' Hospital for Crippled Children, Montreal; Shirley MacPherson and Mary Briggs, the latter two remaining on the staff. The new post-graduate class includes: Edith Hagar, Ann Beechinor, Fern Burger, Verna Shobe, and Beverley Mitchell.

Resignations were accepted during December from Bella Rosenbloom and Pauline Wright, both from the operating-room, and Dorothy Goulet from Ward K who is replaced by Grace Whitehead.

SASKATCHEWAN

HUMBOLDT:

The graduating class of 1946 of St. Elizabeth's Hospital all successfully passed the examinations for nurse registration and admission to the Saskatchewan Registered Nurses' Association.

C. Dauk is taking a public health course at the University of Manitoba.

MAPLE CREEK:

Mrs. E. A. Small recently entertained at a tea in honor of Clara Jackson, director of the nurse placement service for Saskatchewan. Later the members of Maple Creek Chapter were privileged to hear Miss Jackson speak on modern nursing topics and a banquet was also held in her honor. She paid a visit to the high school and the students were advised on "Nursing as a Career."

Misses Guillod and Young and Mrs. W. S. Pollock, president of Maple Creek Ladies' Hospital Aid, attended the annual hospital convention at Saskatoon. Many registered nurses and hospital executives were present. An added feature this year was the one-day institute for superintendents of nurses.

Union Hospital:

Clara Jackson, director, nurse placement service, visited the hospital, obtaining data for her study of nursing conditions in the province. She spoke to the nursing staff regarding the placement service, their work in the hospital, and their place in the community.

The first class of nurses' aides in Saskatchewan, in residence at the hospital, began their course in October under the guidance of Marie Young.

B. Leavens, Lee Laskoski, S. Quarry, and N. Wallace are now on the staff. Mmes Wm. Hurlow and J. L. Malden are assisting, while Mrs. Jos. Armstrong is helping part-time. W. Woods is now operating-room charge nurse. She held this position at Maple Creek Military Hospital.

Prior to her recent marriage, Mrs. H. (Jaster) Fritzke was presented with a table lamp by the Maple Creek Chapter in appreciation of her interest and splendid work on the hospital staff at the time of the fire, when she so capably assisted Miss Guillod in the care of patients transferred to the military hospital.

MOOSE JAW:

Dr. G. Kinncard, regional medical health officer, was the speaker at a regular meeting of Moose Jaw Chapter. Formerly medical health officer with the British Colonial Service, he described the various countries in which he had worked and related amusing incidents which occurred during his twenty years' service.

E. Thorburn and A. Hyer are now on the staff of the Saskatchewan Department of Public Health, Miss Thorburn being at Melfort and Miss Hyer at Assiniboia.

PRINCE ALBERT:

A whist drive, sponsored by the sanatorium staff, realized $12 for the Cod Liver Oil Fund. Mrs. Halpin gave an interesting book review on "Climate Makes the Man."

SASKATOON:

St. Paul's Hospital:

At a recent meeting of St. Paul's Hospital Alumnae Association, Mrs. Gould, society editor of the *Saskatoon Star Phoenix*, gave an informal talk on "Publicity."

A successful tea was held by the alumnae association during the holiday season. The many patrons of this enjoyable function were received by Miss M. Robinson and Mmes R. Anderson and J. Robertson, while registrars were Mrs. J. Wood, M. Schwinghammer and S. Ritchie. Presiding at the tea table were Mmes L. Atwell, H. Nordstrum, B. Sallans, L. McConnell, C. Thompson, and Miss M. O'Hara, while the Mmes M. Rogers, H. Motram, L. Haywood, R. Streeter, M. Barker, Misses S. Ritchie and P. Snell were hostesses. The sewing booth was well patronized and in charge of Mmes W. Briggs, A. Cary, C. Darbellay, N. Smith, and G. Cowell, while at the cooking table were Mmes P. Willms, J. Shelley, Misses L. Lenz, F. Lawley, L. Defaye, M. Henriette, W. Smith, E. Cooper, and E. Worobetz. Mrs. J. S. Miller was the winner of the door prize.

THE ASSOCIATION OF NURSES OF THE PROVINCE OF QUEBEC

The 1947 Spring examinations for provincial registration will cover two groups of candidates and will be held as follows:

GROUP A: Graduates qualifying for the licence to practise will write in Montreal, Quebec, and Sherbrooke on **April 9, 10, and 11, 1947.**

GROUP B: Students who will have completed their first year before **March 1, 1947,** will enter the preliminary test covering oral, practical and written, which will be held on **March 10, 11, 12, and 13, 1947.**

(*Time to be announced in each school.*)

For application forms and all information relating to the examinations apply to the headquarters of the Association.

Applications for preliminaries must be received by **February 28, 1947,** and for finals by **March 30, 1947.**

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Instructor. Ward Head Nurses. General Staff Nurses. Applications are invited from nurses eligible for licensing in the Province of Quebec. In first letter state date of graduation, qualifications, experience, and when services would be available. Apply to Director of Nursing, Verdun Protestant Hospital, Box 6034, Montreal, P. Q.

Nursery Supervisor: $105 per month. **Ward Supervisor:** $110 per month. **Operating-Room Scrub Nurse:** $100 per month. **General Duty Nurses:** $100 per month. All stated salaries include full maintenance. 200-bed General Hospital in Niagara Peninsula. Apply to Supt., County General Hospital, Welland, Ont.

Classroom Instructress immediately for 125-bed hospital. Apply, stating qualifications, experience, and salary expected, to Supt., General & Marine Hospital, Owen Sound, Ont.

Dietitian, preferably with some experience, for 125-bed hospital. Salary: $130 per month plus maintenance. Apply in care of Box 3, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, P.Q.

Dietitian and **Graduate Staff Duty Nurses** (3) for 165-bed hospital. Administrator. Bassinets. Good salaries. 8-hour day and 6-day week. Apply to Mother M. Immaculata, St. Michael's General Hospital, Lethbridge, Alta.

Graduate Nurses (2) immediately for 32-bed hospital. 8-hour day and 48-hour week. Salary: $38.10 per week, less $1.00 per day for board. Apply to Lady Supt., Anson General Hospital, Iroquois Falls, Ont.

Graduate Nurses for **General Staff Duty** at Muskoka Hospital (for Tuberculosis). Salary: $145 monthly for 1st year; $150 for 2nd year; $155 for 3rd year— $30 deducted monthly for full maintenance. Yearly vacation. Cumulative sick leave. Pension Plan. Apply to Supt. of Nurses, Muskoka Hospital, Gravenhurst, Ont.

Obstetrical Supervisor with post-graduate experience for 100-bed hospital with Training School. Apply to Supt., General Hospital, Cornwall, Ont.

Assistant Superintendent. State qualifications and salary expected. **General Duty Nurses.** 6-day week. Hospitalization Plan. Salary: $100 per month with full maintenance. Apply to Supt., Brome-Missisquoi-Perkins Hospital, Sweetsburg, P.Q.

Operating-Room Nurse for Chest Surgery. Eligible for British Columbia registration. Day duty only. 8-hour day; 5½-day week. Gross salary: $125 with increments up to 7th year. Uniforms and laundry provided. 1 month vacation each year with pay. Superannuation. Sick leave with pay, up to 2 weeks for major illness and 6 days for minor illness, accumulative. Live out. Apply, stating qualifications and experience, to Supt. of Nurses, Vancouver Unit, Division of Tuberculosis Control, 2647 Willow St., Vancouver, B.C.

Registered Nurses for General Duty at Vancouver General Hospital, British Columbia. State in first letter date of graduation, experience, reference, etc., and when services would be available. 8-hour day and 6-day week. Gross salary: $125 per month living out, with annual increases up to 7 years, plus laundry. 1½ days sick leave per month accumulative with pay. Employees' Hospitalization Society. Superannuation. 1 month vacation each year with pay. Investigation should be made with regard to registration in British Columbia. Apply to Director of Nurses.

Registered Nurses (2) for General Duty. Straight 8-hour shift; 44-hour week—5½ day week. Gross salary: $126.50 per month. For further information apply to Miss E. W. Ewart, Supt. of Nurses, Mountain Sanatorium, Hamilton, Ont.

General Duty Nurses for 44-bed, fully modern hospital. Salary: $100 per month plus full maintenance. Separate nurses' home. 8-hour day and 6-day week. 3 weeks' holiday with pay after a year's service. Apply to Supt. of Nurses, Municipal Hospital, Grande Prairie, Alta.

Registered Nurses for General Duty at the Toronto Hospital for the Treatment of Tuberculosis, near Weston, Ontario. 8-hour day and 6-day week. Gross salary (straight 8 hours): $150 per month for the 1st year; $155 the 2nd year; $160 the 3rd. For broken hours: $155 per month for the first year; $160 the 2nd year; $165 the 3rd. One day's sick leave with pay per month, accumulative. 3 weeks' vacation per year, with pay. Generous Pension Plan. Apply to Supt. of Nurses.

WANTED—ASSISTANT SUPERINTENDENT OF NURSES

A Graduate Nurse is required for the above position at the Manitoba School for Mentally Defective Persons, Portage la Prairie, Manitoba. Applicant should have had some Mental Hospital experience, and should be capable of teaching in the School of Nursing attached to this hospital.

Starting salary: $135 per month, PLUS FULL MAINTENANCE —accommodation, meals, laundry, etc. This is a permanent position offering one month's vacation with pay annually, sick leave with pay, pension privileges, etc. For full particulars, apply immediately to:

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General Duty Nurses. Salary: $95 per month with full maintenance. Attractive, homey residence recently opened. 1 month's night duty during each 6 months of duty and 2 weeks' holiday with pay for every 6 months of duty. For further particulars apply to Dorothy I. MacRae, Supt. of Nurses, Herbert Reddy Memorial Hospital, 4039 Tupper St., Westmount, Montreal 6, P.Q.

Registered Nurses for **Tuberculosis Hospital.** Salary: $135 per month and meals. 6-day week. Apply to Supt. of Nurses, Royal Edward Laurentian Hospital, 3674 St. Urbain St., Montreal 18, P.Q.

Supervisor of Home Nursing Classes. Must be qualified to later assume direction of Red Cross Home Nursing and Reserve Dept. Applications are invited from Graduate Nurses with Public Health training or experience and executive ability. Apply to Chairman, Home Nursing Dept., Hamilton Branch, Canadian Red Cross Society.